28 April 2007
Chemist+Druggist
Weekly news for pharmacy
www.pharmaj.com

C+D

Pharmacy Champions

AZ selects AAH and UniChem

Industry backs C+D campaign

STOP THE SWITCH

- June vote on royal college?
- AAH conference looks into the future for pharmacy

Fungal nail infection? Punish the Criminails with a once-weekly!

OTC BRAND OF THE YEAR* BACK ON TV AGAIN FROM MAY 2007!

Curanail is the only once-weekly antifungal for mild nail infections with a P-licence.

It is based on the effective[1] treatment previously only available on prescription.

With a new £1.8 million press and TV campaign starting in May 2007, Criminails are running scared!

Order your supply of Curanail today.

PIP Code: 322-0662

It's better to get Curanail than be a Criminail!

Essential Product Information: Presentation: Curanail 5% Nail Lacquer contains 5% w/v amorolfine. **Indications:** Mild distal and lateral subungual Onychomycoses caused by dermatophytes, yeasts and moulds limited to up to 2 nails. **Dosage and Administration:** Adults Only – Apply to the affected finger or toe nails once weekly (see summary of product characteristics for full technique). Treatment duration depends on intensity and localisation of infection. Generally, six months (finger nails) and nine to twelve months (toe nails). Not recommended for use in patients under the age of 18. **Contra-Indications:** Hypersensitivity. No experience in pregnancy and lactation, it should therefore be avoided. **Precautions and Warnings:** Avoid contact with eyes, ears and mucous membranes. Patients with predisposing conditions such as peripheral circulatory disorders, diabetes mellitus and immunosupression should be referred to a doctor. Patients with nail dystrophy and destroyed nail plate should also be referred to a doctor. **Side Effects:** Adverse drug reactions are rare. Nail disorders (e.g. nail discoloration, broken nails, brittle nails) may occur. These reactions can also be linked to the onychomycosis itself.

System Organ Class	Frequency	Adverse drug reaction
Skin and subcutaneous tissue disorders	Rare (≥1/10000, ≤1/1000)	Nail disorder, nail discoloration, onychoclasis
	Very rare (≤1/10000)	Skin burning sensation, contact dermatitis

Interactions: No specific studies involving concomitant treatment with other topical medicines. Avoid nail varnish or artificial nails. **Packaging Quantity and Cost:** Pack containing 3ml nail lacquer, cleansing swabs, applicators and nail files. 3ml **(R) £18.61. MA number:** PL 10590/0049. **Legal Category:** P. **Full prescribing information is available from:** Galderma (UK) Limited, Meridien House, 69-71 Clarendon Road, Watford, Hertfordshire, WD17 1DS. United Kingdom. Tel: +44 (0) 1923 208 950 Fax: +44 (0) 1923 208 999. **Date of Revision:** February 2007.

References: 1. Reinel D *et al. Dermatol* 1992 ; **184** (Suppl 1) : 21-24.

AMO/66/0307 March 2007

Pharmacy training materials are available at

www.curanail.co.uk

*2007 OTC Marketing Awards

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C+D

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www.dotpharmacy.com

Cover: This week's Pharmacy Champion, Ivo Vincour. Picture: Charlie Milligan

AstraZeneca shortlists AAH and UniChem as preferred partners

Wholesale Drug manufacturer awards exclusive distribution rights to two wholesalers

Tom Hawkins

The rapidly changing medicines supply chain took another dramatic twist this week after AstraZeneca signed up AAH and UniChem as exclusive distribution agents.

Chris Brinsmead, AZ's UK company president, told C+D the decision was made after a rigorous review of how the firm's medicines are made available to patients.

"Our critical issue is, how do we absolutely make sure a patient gets the drug they need? That's at the core of it," he said.

"The way the wholesale chain is set up, we're quite a long way from our customers. We want to get more interaction – closer to the people doing the dispensing."

Andy Carr, supply chain director, said AZ did not have a preconceived outcome when the review was initiated. "We kept our options open right to the end. We decided rather late on that two was the route we wanted to go down."

AZ has not finalised details of its discount structure. It is expected to communicate its plans within eight weeks. Mr Brinsmead insisted that AZ will comply with the OFT's recently announced investigation into UK medicine distribution: "We don't think there are any concerns from our point of view."

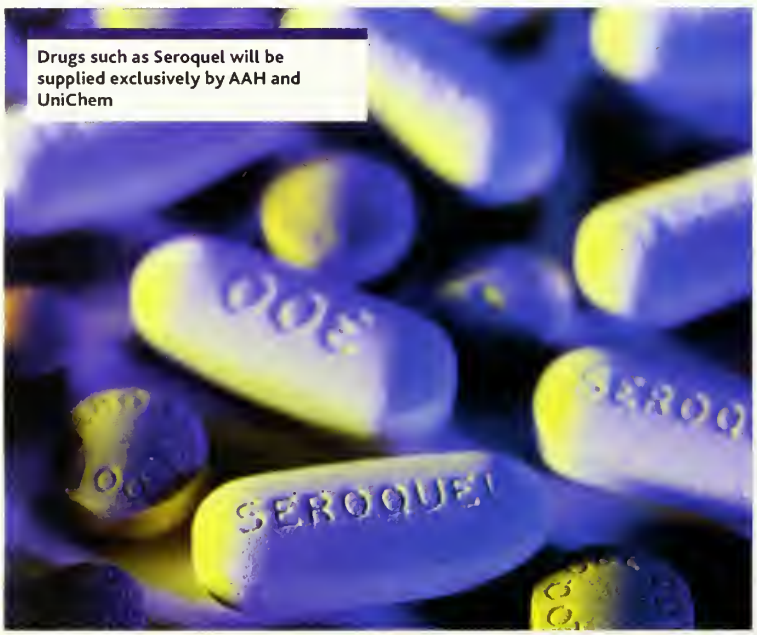
Steve Dunn, group managing director of AAH, said: "By selecting more than one agency partner, the AZ model will ensure that flexibility and choice is maintained."

David Coles, managing director of UniChem, said: "Pharmacists are assured of a partner that understands their business and can maintain ease of ordering and frequency of delivery."

Other drug companies, including Lilly UK and Novartis, are known to be reviewing their distribution. It is anticipated more agency deals could be introduced before the OFT is scheduled to deliver its report at the end of the year.

Andy Carr, supply chain director at AstraZeneca, gives C+D the lowdown on the new system:

- There is no end date to the AAH/UniChem contracts. They will be reviewed on a regular basis. AZ has the ability to add new agents.
- AZ is in talks with AAH and UniChem over a 'go live' date. It hopes to communicate this within eight weeks.
- Existing AAH/UniChem customers will continue to order as normal and cut off times won't change.
- In the event of a stock shortage, AZ retains control to redistribute stock.
- There will be no links between AAH and UniChem's delivery systems.
- Existing delivery frequencies won't change.
- AZ is in ongoing discussions with pharmacy bodies.
- Pharmacists have been informed by letter. There will also be a website.



Drugs such as Seroquel will be supplied exclusively by AAH and UniChem

Your views

It will mean more work and from an environmental point of view there will now be four vans driving to our shops. **Bryan Kidd, Ashludie Pharmacy, Dundee**

Too many pharmacists are making too much of a hoo-ha about this. However, there will have to be better discounts. **Rajesh Vithlani, Peel Green Pharmacy, Greater Manchester**

There's no point in questioning AstraZeneca because they're just like politicians – they tell you what they think you want to hear and then do nothing. **Sharshi Amin, Langley Pharmacy, Beckenham**

AZ deal triggers concern

Wholesale Fears of 'copycat' activity across industry

AstraZeneca's strategy of choosing two agency partners has failed to pacify pharmacy representatives.

Welsh contract negotiators Community Pharmacy Wales said it would be seeking to meet with the company "at the earliest opportunity" to discuss the proposals.

Chief executive Peter Haydn Jones said: "We are concerned at the general direction of travel being taken by the manufacturers and the long-term implications of this for both patients, the NHS in Wales and pharmacy contractors."

Scottish contract representative, the Scottish Pharmaceutical General Council has also highlighted "continuing concern" over competition and choice for pharmacists and patients, product supply, increased administration and discounts.

NPA chief executive John D'Arcy said: "What we feared is that Pfizer's decision would open the floodgates to similar schemes. The AZ decision means we are now seeing 'copycat' activity across the industry – how many more different distribution schemes will follow?"

Numark managing director Simon Colebeck criticised the OFT for not preventing further changes. He said: "If the OFT had seen a way of halting all this and reflecting then it would have been a sensible move." **AC**

Another blow to wholesaling

Wholesale BAPW warns changes could destroy sector

Pharmaceutical wholesalers have been rocked by AstraZeneca's decision to sign up AAH and UniChem in an exclusive distribution agreement.

The move deals another blow to wholesalers already excluded by Pfizer's solus distribution arrangement with UniChem. Paul Smith, chief executive of Phoenix, said the move would have a "major effect" on its business.

"It's going to mean some major changes to wholesalers. How severe that is depends on how we can move our business," he said.

Phoenix said its comprehensive full-line service was in question as a result but that it had yet to make a decision on where to introduce cost savings.

"We're not going to overreact to this change. We've got our customers and staff to think of and we regard them very highly," said Mr Smith.

Ian Brownlee, managing director of Mawdsleys and chairman of the British Association of Pharmaceutical Wholesalers, said the move further upsets the framework of the wholesale sector and could contribute to it being destroyed.

"Ultimately, you're moving down the profit leagues so at some point you break even and then you lose money." **TH**

To support Stop the Switch sign the petition at:
www.dotpharmacy.com/stoptheswitch

"We support C+D Stop the Switch campaign"

Campaign Industry unites behind our bid to make the MHRA rethink POM switch

Wesley Yin-Poole

Pharmacy chiefs have overwhelmingly backed C+D's campaign to defend contractors against plans to reclassify medicines containing pseudoephedrine and ephedrine as prescription-only.

Hemant Patel, president of the RPSGB, said: "I am behind C+D's Stop the Switch campaign, as is the RPSGB's Council. It's vital we oppose reclassification and focus on how we can make pharmacists more aware of the potential problem."

Rob Darracott, chief executive of the CCA, added: "An important question is how do we get to the point where everybody in pharmacy understands what this issue is about. C+D's campaign will play its part in achieving that. It is very helpful."

Under the banner of Stop the Switch, C+D will push for the Medicines and Healthcare products Regulatory Agency (MHRA) to reconsider its radical suggestion to switch medicines from P to POM.

The campaign will also champion the important role pharmacy can play in controlling the supply of such medicines, which can be used to manufacture the highly addictive drug methylamphetamine (crystal meth).

Leading MPs endorsed C+D's call on the government to rethink reclassification plans.

Sandra Gidley, Liberal Democrat spokesperson for health, said: "You can count on my support for this campaign. Whilst I recognise the government's concern over crystal meth abuse it appears they are using a sledge hammer to crack a nut."

The deadline for submitting evidence to the MHRA's consultation has been pushed back from June 1 to June 29 "in light of external interest and questions". The MHRA is making more details on the evidence available next week.

What is it all about? See p16 >

Support from across the country

Peter Haydn Jones, chief executive, Community Pharmacy Wales (CPW):

"We support C+D's campaign. Any campaign that points out the key issues to the MHRA must be a good thing."

Steve Lutener, head of regulation, Pharmaceutical Services Negotiating Committee (PSNC):

"PSNC supports C+D's Stop the Switch campaign. It has highlighted that the pharmacy bodies are united in their opposition to legislative intervention, where professional controls are more than adequate, and we hope that the MHRA reconsiders the options."

Harry McQuillan, chief executive officer, Scottish Pharmaceutical General Council (SPGC):

"We're fully supportive of C+D's campaign, because, especially in Scotland, our new contract is about opening access to care, and this goes against that. Reclassification would be a retrograde step."

Sandra Gidley MP, Lib Dem spokesperson for health:

"The switch proposals counter the government's desire to give pharmacists extra responsibility. There may be more controls needed but that's something that can be addressed by the profession."

Paul Bennett, chairman, English Pharmacy Board (EPB):

"I applaud C+D for raising the argument. This is an opportunity for pharmacy to demonstrate it has the ability to prevent inappropriate sales, as we do already, particularly in community pharmacy at the moment."

Colette McCreedy, acting chief executive, NPA:

"C+D's Stop the Switch campaign is very important and the NPA is totally behind it. We need to demonstrate we can tackle this problem with increased awareness and training. A POM switch is not the way to tackle crystal meth abuse."

Consumer watchdog slams switch plans

Campaign Which? adviser says switch 'reduces choice'

A consumer watchdog has spoken out against the MHRA's plans to change medicines containing ephedrine and pseudoephedrine from pharmacy to prescription-only status.

Speaking at a meeting between the primary care and public health and drugs misuse parliamentary groups in Westminster last week, Kate Webb, Which? principal policy adviser, warned that a switch would "reduce consumer choice" and give a "confusing message".

Ms Webb described the MHRA's proposals as "counter to government policies" and "not an appropriate response".

Ms Webb's comments were echoed by Dr James Kennedy of the Royal College of General Practitioners (RCGP), who said a switch "wouldn't necessarily solve this problem".

Dr Kennedy said it "would have a big impact on doctors' workloads and NHS costs".

Summing up the debate, which saw representatives of the police, the MHRA, the RPSGB and pharmaceuticals industry offer their thoughts on the controversial proposals, chairman Dr Howard Stoate predicted the change in status would hinder his work as a GP.

He said: "Whenever I see patients with ailments that could be treated by their local pharmacist I send them back there. That's the aim we're trying to achieve with the NHS and these proposals go against that." **WYP**

News in brief

NCSO update

The Department of Health and the National Assembly for Wales have agreed to allow NCSO endorsements for the following item for April 2007 prescriptions – mefenamic acid 250mg capsules.

PPD not being privatised

The Prescription Pricing Division (PPD) will not be privatised or outsourced, the government has announced. Karen Jennings, UNISON head of health, said: "The drugs industry is worth billions and it is essential that the information gathered by the PPD is secure. This would have been threatened by any attempts to privatise the service or send the work abroad."

New board for NPA

The National Pharmacy Association (NPA) has appointed Dilip Joshi as chairman for 2007-08. Sean Woodward is named vice-chairman and Wally Dove has been re-elected as treasurer.

OTC city break prize

Non-pharmacists take note. Tell us what you think of Over the Counter magazine and be in with a chance of winning a weekend city break in Europe.

Find the survey form in April's OTC, delivered with C+D April 21, fill it in and send it through to us by the end of May. Remember – pharmacists can't win, it's for pharmacy support staff only.

Lloyds buys pharmacies

Lloydspharmacy has acquired 63 pharmacies, bringing its total to more than 1,600. Of the acquisitions, 29 are from Manichem and 34 are from the Independent Pharmacy Care Centres chain.

CPD guide on CPPE site

The Centre for Pharmacy Postgraduate Education (CPPE) has put together a short CPD guide, now available for download via its website www.cppe.ac.uk

It is intended to help community pharmacists consider how they can use the results of the Community Pharmacy Patient Questionnaire to inform their continuing professional development.

Royal college: June vote?

RPSGB Pharmacists could vote on royal college status within next few months

Wesley Yin-Poole

Pharmacists could be given the vote on whether the Royal Pharmaceutical Society becomes a royal college this June, the RPSGB president has revealed.

Hemant Patel told C+D that a ballot could take place as soon as members had been fully informed on the RPSGB's plans. "A ballot without proper discussion is not on the agenda. We need a wider discussion around membership of technicians and revalidation. I doubt a vote will run before June or July."

The RPSGB has called a meeting with pharmacy stakeholders on April 30 to discuss "the challenges and benefits of a new pharmacy body".

The RPSGB is seeking backing to become the professional leadership body set out in the government's white paper on healthcare regulation this February.

Paul Bennett, chairman of the newly formed English Pharmacy Board of the RPSGB, said he hoped there would be an "opportunity for all members of the Society to have an option to express their opinion".

Mr Bennett said the meeting with pharmacy representatives plans to give "an impression of what they would like to see from the formation of a royal college".

At the time of going to press, the Society had received 20 positive responses from parties interested in attending the meeting, including the BPSA, CCA, NPA and PSNC.

The latest EPB meeting addressed the future of the Society and practice-based commissioning. Mr Bennett described the EPB as "very much a work in progress".

• The Scottish Pharmacy Board of the RPSGB has pledged to improve communication with its members and called on the Society to support a flat retention fee to be "borne by the profession as a whole". At only its second formal meeting, held last week, it was agreed elected board members would be "twinned" with each Scottish branch.

Carter complete

The Carter working party, set out to implement healthcare regulation reforms, has met for the final time and Lord Carter has submitted his recommendations to pharmacy minister Lord Hunt of King's Heath.

Pharmacy Champion Brian Deal struts his stuff at the AAH Pharmaceuticals conference in Singapore during the Bollywood night at the spectacular Fort Canning Park. For C+D's full report on the conference and how pharmacists must prepare now for the possibility of significant changes in the way they do business in the future, turn to page 40

US giant set for Alliance Boots takeover

Multiples Increased KKR bid for Alliance Boots sees rivals drop out of race

Stefano Pessina and private equity firm KKR are poised to take control of Alliance Boots in a £11.1 billion deal after the rival bidders dropped out of the race.

Terra Firma and medical research charity Wellcome Trust withdrew their interest in the pharmacy giant this week after a higher KKR bid snuffed out the prospect of a prolonged bidding war.

The £11.39 per share offer tabled by KKR and Pessina was backed by the Alliance Boots board. Shareholders are expected to vote on the proposal by the end of June.

The £11.1bn price tag marks a £500m premium on the £10.90p bid offered four days previously by KKR and Pessina, which chairman Sir Nigel Rudd already felt delivered "a good price for shareholders".

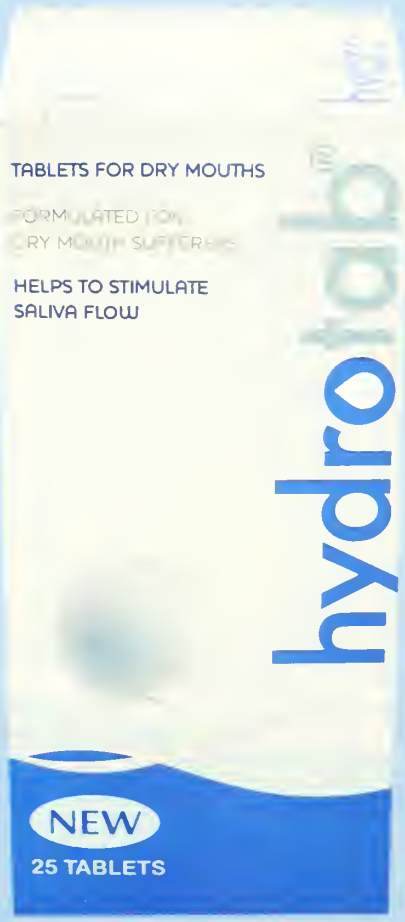
Good sign? Boots buyer KKR rules out pharmacy closures

The increase, prompted by a £11.26 rival bid by Terra Firma, Wellcome Trust and HBOS plc, has led to speculation over how the bidders will secure a return on their investment.

The GMB union called for the secretary of state for health Patricia Hewitt and ministers for the NHS in Scotland and Wales to get assurances from the bidders that a private equity takeover will not lead to pharmacy closures.

KKR has previously emphasised that it does not intend to close village pharmacies if it gains control of Alliance Boots, describing them as the "backbone" of the business. **TH**

SALIVATION



FOR DRY MOUTHS

120 million prescriptions a year cause dry mouth.[1] That's a lot of people. And, now there's something you can do about it, a massive medicine usage review opportunity for your pharmacy.

hydrotab is a sugar-free tablet that helps stimulate saliva flow to relieve dry mouth. It's supported with a £1 million launch campaign and, in research, 73% of respondents said they'd buy it if you recommended it.[2] So go ahead, save their day.

hydrotab

Formulated to make your mouth water

actavis

creating value in pharmaceuticals

1. Actavis data on file. Based on the BNF and MAT data. 2. Actavis data on file. Ipsos-MORI poll of 155 customers

News in brief

Polls apart

UniChem has refuted the findings of a poll by rival AAH, which claims 62 per cent of 350 independent UK pharmacists surveyed are dissatisfied with the supply of Pfizer products.

In a statement, UniChem said: "[UniChem] has recently carried out courtesy calls to over 7,000 Pfizer-only customers (excluding UniChem first line and second line customers), which have confirmed that over 95 per cent are satisfied, or more than satisfied, with the service UniChem is providing."

Turn to page 40 for the full story.

Framework updated

Primary Care Contracting has updated its Community Pharmacy Assurance Framework (CPAF) and Community Pharmacy Strategic Commissioning tests.

The CPAF document incorporates the pre-visit questionnaire and the new standards for better health in one document. Contractors are invited to comment on the document until the end of May.

For further information see: www.primarycarecontracting.nhs.uk/114.php

Illicit drug use falls

In 2005-06, 10.5 per cent of adults had used one or more illicit drug in the previous year, a decrease from 12.1 per cent in 1998. Class A drug use has increased, however, and is most common in London. Illicit drug use is generally highest in the south west of England. The Information Centre report, Statistics on Drug Misuse, England, 2007, makes no special mention of crystal meth.

Nucare guide

Nucare has produced an MUR guide for use in consultation areas that enables pharmacists to advise patients on the possible side effects of commonly used medicines during their MUR. It is available to download from http://nucare.co.uk

Asthma tips

Numark has launched an asthma pack to assist professionals with diagnosis. The guide includes tips for asthma MURs and marks World Asthma Day on May 1. See www.numarkpharmacists.com

Pharmacy pushes for patient record access

Politics Pharmacy organisations take case to parliamentary evidence sessions

Ailsa Colquhoun

Pharmacy bodies will step up the campaign to gain pharmacist access to the electronic patient care record in a series of parliamentary evidence sessions taking place this June.

The NPA, PSNC, CCA and the Association of Independent Multiple Pharmacies are expected to make the case for role-based, read and write access to the shared electronic patient record. PSNC is also to express its disappointment at the lack of involvement of community pharmacy so far in the Care Records Service (CRS).

Noting the imminent launch of the summary care record, PSNC head of information services Lindsay McClure said: "To study the benefits and challenges that arise in joining up care, we believe that community pharmacists should be involved at an early stage."

But government watchdogs have recently warned that the final phase of the CRS, when the detailed shared electronic patient record will go live, is likely to be at least two years' behind schedule.

In a report into the National Programme for IT, the House of Commons Public Accounts Committee highlights specific problems affecting the CRS, but not the Electronic Prescription Service, which is currently on time and to budget.

"The Department has much still to do to win hearts and minds in the NHS, especially among clinicians. It needs to show that it can respond constructively to feedback from users."

Independent IT consultant Geoff Mackay added: "It's inconceivable that pharmacists won't have access to the care record. Ensuring the continuity and safety of prescribed drugs is a key aspect of patient care."

In the loop: pharmacy will make its case for access to patient care records

Good health: Alphington Pharmacy in Exeter has relocated from a quaint Devon thatched cottage to premises five times the size at Ide Lane Surgery. Proprietor George Wickham opened the premises exactly 80 years after his grandfather first opened a pharmacy in Exeter

UK takes safety lead

Europe Report champions pharmacy role across UK

UK community pharmacists are leading the way on patient safety, according to one of the authors of a Europe-wide report.

The report, Maximising Patient Safety in Europe, from the Pharmaceutical Group of the European Union (PGEU), which represents European community pharmacists, calls for a systematic approach to patient and medicine safety issues.

Colette McCreedy, acting chief executive of the NPA and secretary of the UK delegation of the PGEU, said: "Pharmacists have an important role to play from checking prescriptions to managing medicine usage.

"UK community pharmacists are among the best in Europe at tackling these issues," she added. **WYP**

Old enough to know better

Practice Study finds elderly resist information

Pharmacists and others should not simply assume that commonsense interventions during medication reviews with patients over 80 will lead to health gains.

The call comes in the conclusions of a research paper published in the BMJ this week.

The paper describes a large study designed to explore the pharmacist's advice-giving role during medication reviews with elderly patients.

The study found that pharmacists provided a large amount of advice and instruction, even though the elderly patients rarely asked for information.

The information provided was frequently resisted, creating awkward interactions during the consultations.

Patients often showed resistance by displays of knowledge or authority, as well as by calling on higher authorities such as the hospital or GP. **GMA**

STOP

THE SWITCH

C+D PETITION

Community pharmacy is urging the Medicines and Healthcare products Regulatory Agency to reconsider its plans to change the status of medicines containing pseudoephedrine and ephedrine from pharmacy (P) to prescription only (POM) status by the end of this year.

This means you would no longer be able to buy leading cold and flu decongestant remedies from the pharmacy. You would need to see your GP for a prescription. The MHRA wants to change these products to prescription-only because the active ingredient can be converted to an addictive Class A drug. We believe that stricter controls on the sale of these products will limit the diversion of products for illegal use but will ensure you can still buy your regular cold and flu remedies from a pharmacy.

For these reasons we are urging the MHRA to Stop the Switch. Please add your name below to support our campaign. Thank you.

WE THE UNDERSIGNED URGE THE MHRA TO STOP THE SWITCH OF MEDICINES CONTAINING PSEUDOEPHEDRINE AND EPHEDRINE FROM PHARMACY TO PRESCRIPTION ONLY

Name	Address	Signature

Please photocopy as needed or download more forms from www.dotpharmacy.com/stoptheswitch

Send completed petitions to: C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE

Stop the Switch – you respond

Change of status would send out the wrong message

I believe that the proposed switch of pseudoephedrine and ephedrine is fundamentally wrong and sends out the wrong message concerning the role of pharmacy in monitoring the sale and supply of medicines in the community.

Pseudoephedrine and ephedrine have been around for many years and have been used safely as decongestants. Currently there are 103 medicines containing pseudoephedrine and 32 containing ephedrine, which are used as cough and cold remedies. Pharmacists advise on interactions and contraindications of these medicines, and control sales to prevent abuse.

The MHRA has decided that these products need to be reclassified to POM status in order to prevent a few people attempting to convert these products to methylamphetamine while at the same time denying these safe and effective products to the general public.

Drug abuse is part of modern life and, even if pseudoephedrine is reclassified, drug abusers will find a way of obtaining methylamphetamine. Other drugs such as diamorphine and diazepam are controlled drugs and yet are freely available on the streets. If there is a demand for a product then someone, somewhere will fill that demand, legal or not.

In my opinion the MHRA's course of action should be to promote awareness to all medical professions and to the public. Pharmacists have shown on numerous occasions that they are more than capable of monitoring sales and we can easily put in place protocols to manage the sales of these products effectively. Pharmacy has the ability to regulate sales of these products without the need for reclassification of pseudoephedrine, which would be a step in the wrong direction and send out the wrong message.

Kevin Cottrell, head of professional services, Day Lewis

Switch ignores needs of users

Knee-jerk responses by government (if in doubt, legislate) over such issues do not work. Remember dangerous dogs, knife and gun amnesties, conifers and the right to light etc?

This must surely be the best example of where the needs of the huge majority of innocent, legitimate users will be ignored as the authorities ineffectually attempt to frustrate the perceived threat.

Why should we lose the ability to supply long-established and effective remedies to sufferers? Isn't the record of community pharmacy in protecting the public from harm through abuse worth anything?

A ban on OTC packs as a source of crystal meth raw material in the UK is hardly likely to stop the traffic – heroin, cocaine and also substances not found in licensed medicinal products still manage to find their way onto our streets.

I appreciate the terrible health consequences that the use of crystal meth brings to its victims; however, our ability to challenge this threat cannot be met by a simple ban on pseudoephedrine-containing medicines.

Tim Burrows MRPharmS superintendent pharmacist Brocklehurst Chemists, Hull

Your letters

No loss of direction, says NPA

Xrayser (C+D, April 7, 2007) includes in his concerns about the waves of change crashing over him that "our recently rechristened and reshaped NPA has only a temporary leader and an apparent loss of direction".

Although it is true that we will have an acting chief executive for a while, it does not follow either that we are without a rudder or that we have lost direction. As the NPA is governed by a board of management and has a strong and experienced executive team, having an acting chief executive is not the disadvantage it might have been to a business before the days of modern management.

As for "an apparent loss of direction", it is hard to understand how Xrayser can have gained such a wildly inaccurate perception. To continue with the nautical metaphor, the NPA is a soundly constructed ship and having a temporary beam does not mean that the ship can no longer continue its passage to the desired destination.

The NPA was "recently reshaped", as Xrayser puts it, to ensure that its structure would withstand "waves of change". Its leaders have given it a clear strategy and well defined, published business plan with which to chart the waters over the coming months. Perhaps Xrayser would like to let us know, either directly or through the pages of C+D, what prompted such an irrational comment.

Virginia Mead-Herbert
NPA marketing director

One stop to closure?

Andrew Murray suggests that out-of-town one-stop health centre pharmacies do not affect the other local pharmacies (C+D, April 14, p16).

I disagree: such one-stop centres impact on the turnover of existing local community pharmacies, and consequently the goodwill of the business. Being close to surgeries gives health centre-based pharmacies an advantage in attracting prescriptions – but Mr Murray thinks that existing contractors will continue to maintain a high volume of repeat prescription business as they are providing a convenient service for patients.

Mr Murray rightly adds that ultimately this is all about competition and that should improve the quality of service to the patient. However, if he believes this, then would he object to other pharmacies opening in the same health centre, giving patients a choice over where they get their prescriptions dispensed? Mr Murray knows very well that this could never happen since no-one would be allowed to open another pharmacy in the same one-stop health centre.

Kirit Patel is correct to state that, in order to protect the existing pharmacy network, one-stop healthcare centre pharmacy contracts should be offered to a consortium of local contractors. Mr Murray disagrees on the grounds that this will create another level of complexity when looking to invest in premises and service development and he says he will always do what he feels is in the best interest of patients. But, if you do not try to form consortia, one would never be the wiser whether this route is going to work out.

Ashwin Tanna
community pharmacist

For or against out-of-town one-stop health centres? Email us at haveyoursay@cmpmedica.com

Locum at large

Credit where it's due

Our locum columnist has his faith in the profession restored, both in and out of the pharmacy

Two events have occurred that made me think pharmacy is not all the doom and gloom that so many people make it out to be.

The first occasion was when I received an invitation to address a church group, including many carers, on my work as a pharmacist. "I don't know how many people will turn up," said the vicar. "Sometimes we only get a few." Cometh the hour, I arrived at the hall and walked in. The place was packed, standing room only.

Was this a case of my well known charisma exerting its influence, my reputation as a superb after-dinner speaker having spread to the furthest corners of the county? Or did all these people want to have a crack at me about their medication or some aspect of their experience in their local pharmacy?

I need not have worried. I had an extremely attentive audience, anxious to hear what I had to say and eager to learn about the work of their local pharmacy and how pharmacy fitted in to the great scheme of our National Health Service. Their interest and goodwill was palpable and the Q&A session lasted longer than my original address.

I was bombarded with questions from all parts of the hall about prescriptions, medication, side effects, dispensing errors (mercifully few) and a host of queries about their experiences in their local pharmacy.

That everyone had such a high opinion of their local pharmacy and pharmacist, whether it was privately owned or part of a group, was most gratifying and I came away feeling that there may not be too much public praise for pharmacy in the media but at local level many people are deeply appreciative and grateful for the service and support that they receive from their local pharmacist.

The second occasion, or rather occasions, was when I was privileged to work in three pharmacies that to me were shining examples of what a good pharmacy should be. Beautifully clean, modern, well stocked, with adequate numbers of staff who all knew their roles, it was a delight to work in all three. They all had lady managers who lead by example, being the hardest working member of the team. Discipline was rigid, with every assistant knowing exactly what their job was and what was expected of them. The branches ran with quiet efficiency, all were very busy and I was immediately swept up by the sheer momentum of the manner in which all three businesses functioned.

Thinking about it afterwards I came to the conclusion that the key factor to achieving such a standard of performance and success boils down to that simple word – leadership. All three branches have first class managers who run their branches firmly yet fairly and where the manager respects and supports her staff and they reciprocate.

At all times everyone was cheerful, positive and obviously enjoyed and derived satisfaction from their jobs, each feeling they were doing something worthwhile. I was looked upon not just as a locum there for the day but as a full member of the team. Their expectation of me was high – and so it should be – from the moment I walked in.

All in all, it made me realise that much of the aforementioned doom and gloom is overdone and that there is much in our calling that is good and worthy of appreciation.

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Comment from the editor

Wholesalers and pharmacists prepare for a raft of change

There was never any real doubt that Pfizer's direct to pharmacy distribution deal would be the signal for other manufacturers to follow suit.

Eight weeks after Pfizer's deal went live, AstraZeneca has announced its distribution plan, with AAH and UniChem as the appointed agents. And, with other manufacturers already making noises about reviewing their delivery mechanisms, we are likely to see a raft of new schemes over the summer. For both wholesalers and pharmacists, the changes are having major consequences.

Wholesalers have now lost an estimated 20 to 25 per cent market share to the distributors and, in a market where the margins are notoriously wafer thin, losing a quarter of their turnover will see some players come under increasing financial pressure. For example, what happens to Phoenix and Mawdsleys? While the former has a European presence and owns a retail chain, the latter must seriously review how it reacts to the changes.

And with full details of AZ's scheme still to be made public, what will the impact be on contractors? If you thought the paperwork associated with your contract was over the top, think about having to process invoices for individual manufacturers, each with its own discount structure, delivery schedules and quota levels.

With the increased workload, not to mention the loss of purchase profits, perhaps you're better off converting your accredited checking technician and consulting room into a practice manager and office.

While in England and Wales there is a guarantee of minimum purchase profits, contractors in Northern Ireland and Scotland have no such backup.

The OFT has promised to report at the end of the year, but one wonders what use this will be with the industry undergoing such rapid change.

And, as if all this wasn't enough to contend with, PSNC chief executive Sue Sharpe highlighted, at last weekend's AAH conference, the government's increasing use of centralised procurement to deliver better value for money for taxpayers. The funding details for the contract in England and Wales cannot come soon enough.

Stop the Switch

The industry support for C+D's Stop the Switch campaign clearly shows the depth of feeling among pharmacists and pharmacy bodies. Pledge your support by signing our petition on the Prime Minister's website which you can reach via www.dotpharmacy.com/stoptheswitch, and get your customers to back the campaign by signing the form on page 10.

Thank you for your support.

The funding details for England and Wales cannot come soon enough

Your views

Pharmacists in double jeopardy

Mark Koziol suggests that the pendulum has swung too far in disciplinary procedures against pharmacists

April 1 was a watershed date at the Society in as far as the regulation of pharmacists is concerned. The old, often criticised RPSGB regulatory system, was replaced by a new one as governed by the much-awaited Section 60 Order.

Under the new system there are now six statutory committees, large numbers of extra personnel, significant additional costs to the membership and a whole host of new powers for the Society. These new powers include suspension from practice, notification of employers in the event that a pharmacist has had an allegation made against them (even if this is unfounded) and even cost orders made against pharmacists who find themselves the subject of a disciplinary hearing.

It has been the firmly held view of the PDA that many of these powers are contrary to the Human Rights Act. Moreover, we have often stated that a suspect in a murder investigation enjoys more rights than a pharmacist or technician who is unfortunate enough to be embroiled in a disciplinary investigation of the RPSGB.

In the last few weeks since April 1, the RPSGB has re-opened cases against pharmacist members, some of whom had previously self-reported as they were temporarily ill and moved themselves to the non-practicing register.

Some of these pharmacists were subsequently returned to the practicing register by the Society after their health had been restored.

In one such case, a pharmacist who had been thoroughly investigated by the previous regime on the grounds of ill health had subsequently been passed fit to practise following a medical report from the Society's nominated medical specialist.

This pharmacist had only just put that episode behind him and started to rebuild his career. However, he has now been referred for investigation, with no evidence of current ill health, using the Society's new powers. He will have to go through the entire process again. This time, under new powers, he will be required to provide the Society with his full medical history going all the way back to his childhood years. He may have to agree to a suspension and a refusal to co-operate will result in an immediate referral to the disciplinary statutory committee with allegations of misconduct levelled against him.

If there were anything that could affect a person's health or sanity, surely this kind of treatment would be it. There comes a point where decent people everywhere, be they pharmacists, politicians or even members of the public, will accept that this is regulation gone mad and has no place in our modern society and it must be challenged. It cannot be the case that the new regulatory legislation is designed to be used in this way.

At the PDA we will be working to bring these concerns to the attention of the appropriate bodies.

Mark Koziol is chairman of the Pharmacists' Defence Association

Xrayser

Xrayser C+D

Our priceless services must be valued

C+D's Stop the Switch campaign (C+D, April 21, p5), will prove priceless if it helps to raise awareness of the potential retrograde switch of pseudoephedrine from P to POM . But it is only really necessary because, once again, the wider world has failed to appreciate the value and potential of community pharmacy's contribution to healthcare.

I'm 100 per cent sure that pharmacists would be missed if we disappeared completely. Yet because we offer such a huge range of services to the community, when small elements of our work are chipped away we always make up for it in other areas. Therefore individual losses are always difficult to measure.

Because we were there to pick up the pieces after the oxygen supply fiasco, for example, we effectively managed our own demise in that area and prevented the large-scale catastrophes that would have made national headlines. Now the local hospital is picking up the emergencies and it's impossible to measure whether any overall savings have been made or not.

Our work with drug addiction services is another area where our contribution is indubitable, yet because it is not easily measurable or valued it is high on the list when cost savings need to be made. In order to make these cost savings, our local drug and alcohol team want to cut by more than half the fees they pay for supervised methadone services. They also want to reduce the number of weeks that addicts are supervised and switch most to weekly supplies.

While I sympathise with their need to cut costs, these initiatives are not cost effective for the wider community. The cost of more methadone becoming available on the black market is difficult to assess but will involve the police, social services and the NHS, to mention but a few that will foot the bill. While supervising methadone administration may be a fairly straightforward task, it is immensely valuable and worth much more to the community than our small fee alone.

There are countless other 'priceless' tasks we perform for small, or no, fees. Because we're not paid a separate fee for safely supplying OTC medicines, for example, it's assumed that the job has no value. Likewise, because our advice is free, medicines are switched glibly from P to GSL.

Initiatives such as the relaunch of the NPA's 'Ask Your Pharmacist' campaign' and Numark's advertising campaign (C+D, April 21, p6) could not have been better timed. Our profile must be high and our talents valued. The longer we are taken for granted the more likely we are to remain downtrodden.

The right drug, the wrong indication

The recent application to switch naproxen from POM to P is a move in the right direction. But while I know that beggars can't be choosers, this isn't quite the switch I'd hoped for. Naproxen for musculoskeletal pain would be great news, particularly for all those patients asking for 'stronger' pain relief for their pulled muscle or temporarily aching joints. But this application is for a dysmenorrhoea treatment.

While I'm sure that this will be a useful therapy for some patients, I'm not convinced that it will attract that many extra sales. Of course the key will be in the marketing but I don't see that many prescriptions for this indication so I wouldn't expect OTC sales to be vastly different.

Xrayser C+D

24 tablets inside

Black Bag

Breaking good news

Hey, know what TATT means? How about FUBAR? These glorious old acronyms were once common in doctors' notes. Time and, more to the point, lawyers trawling through juicy old patient files saw off 'Tired All The Time' and 'Messed Up Beyond All Repair', or words to that effect. Gone are the days when you could write a single line such as 'obviously supratentorial' to explain the undiagnosable.

When it came to symptoms, a dividing line between reality and imagination followed the brain's own division above and below the tentorium. According to Aristotle, women suffer most from this affliction, hence the medical term 'hysteria'. By definition, only women can have their womb wandering around the abdomen causing all manner of medical problems and only fixed in place through either oral sulphur or, better still, pregnancy.

Telling someone there is nothing wrong with them is a tricky business not least because the popular press would have us believe

> The popular press would have us all believe that we suffer from a terminal illness. The problem is, it's true

that we all suffer from a terminal illness. The problem is, it's true.

Measuring how good you are as a doctor can be a tad problematic when all GPs have a 100 per cent patient death rate. It's probably easier to convince a person they have a hitherto unheard of tumour which takes around 30 years to kill them rather than saying they will live to a ripe old age on top of their accrued 80 years.

In A&E I once returned with an X-ray film to tell a young man that his arm, injured in rugby, was thankfully not fractured. He almost dissolved into tears. "It must be bust Doc, I've told everyone," he lamented. I gave him the name of a good wrestler. Breaking good news, not to mention arms, can be very hard these days.

Dr Ian Banks is a GP practising in Northern Ireland

A sledgehammer to crack a nut?

STOP THE SWITCH

Max Gosney asks if the government has gone over the top in its battle to beat crystal meth abuse

What's crystal meth got to do with pharmacy?

Some of your most popular flu remedies are likely to feature pseudoephedrine and ephedrine. These compounds can also be used to make a class A drug, methlyamphetamine. The highly addictive drug, also known as crystal meth, stimulates euphoria and wakefulness with long-term use leading to paranoia and severe depression. The UK has a relatively low level of crystal meth use compared to the USA, Australia and New Zealand. However, police claim an outbreak is imminent and criminals may target pharmacies as they look to capitalise on rising demand for the drug. The MHRA claims a reclassification of these products to POM status will act as a "pre-emptive strike" against a crystal meth epidemic.

Will POM be any safer?

Anti-crime agencies are unable to offer any compelling figures on the amount of crystal meth sourced from pharmacy precursors. The Serious Organised Crime Agency (SOCA) admits it has "relatively limited evidence" of widespread methylamphetamine production in the UK. David Bolt, director of intelligence at SOCA, says: "We have little hard evidence of organised criminal involvement in this drug. But we are concerned about the potential threat." However, police officials did reveal the discovery of 3kg of crystal meth on the south coast of England believed to have been imported from Europe. The haul casts doubt on the effectiveness of restricting pharmacy sales on the wider crystal meth problem, says Dr Brian Iddon, Labour MP for Bolton south east. "It's my belief that if you go to POM the drug will just be sourced from other countries and the internet. I think you will only succeed in displacing the problem through this measure along with causing enormous upset to pharmacists and patients."

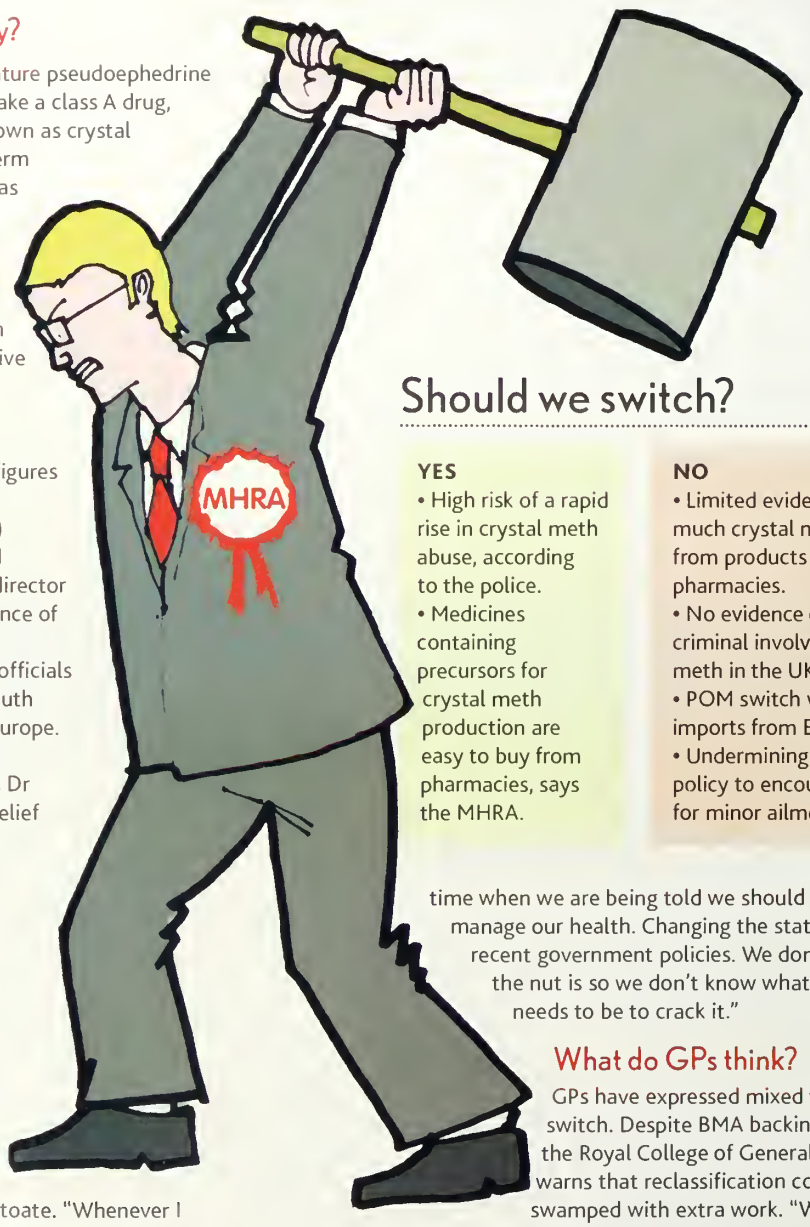
What about giving pharmacists more responsibility?

Proposals to stop pharmacists selling safe and clinically effective medicines contradict Westminster's bid to boost pharmacy's NHS role, says Labour MP and GP Howard Stoate. "Whenever I see patients with ailments that could be treated by their local pharmacist then I send them back there. That's the aim we're trying to achieve with the NHS and these proposals go against that."

What about patient choice?

Another favourite from the government's phrase book. However, it appears to have been torn out under the MHRA's proposals to reclassify pseudoephedrine and ephedrine-based medicines, says Kate Webb, principal policy advisor at consumer group Which?. "Moving 130 products from the shelf reduces consumer choice and gives a confusing message at a time when we are being told we should be doing more to manage our health. Changing the status is counter to recent government policies. We don't know what size the nut is so we don't know what size the hammer needs to be to crack it."

Show your support for the Stop the Switch campaign by encouraging your customers to sign the petition on page 10 or visit www.dotpharmacy.com/stoptheswitch



Should we switch?

YES
- High risk of a rapid rise in crystal meth abuse, according to the police.
- Medicines containing precursors for crystal meth production are easy to buy from pharmacies, says the MHRA.

NO
- Limited evidence as to how much crystal meth is produced from products bought at pharmacies.
- No evidence of organised criminal involvement in crystal meth in the UK.
- POM switch won't stop illegal imports from Europe or Asia.
- Undermining government policy to encourage self-care for minor ailments.

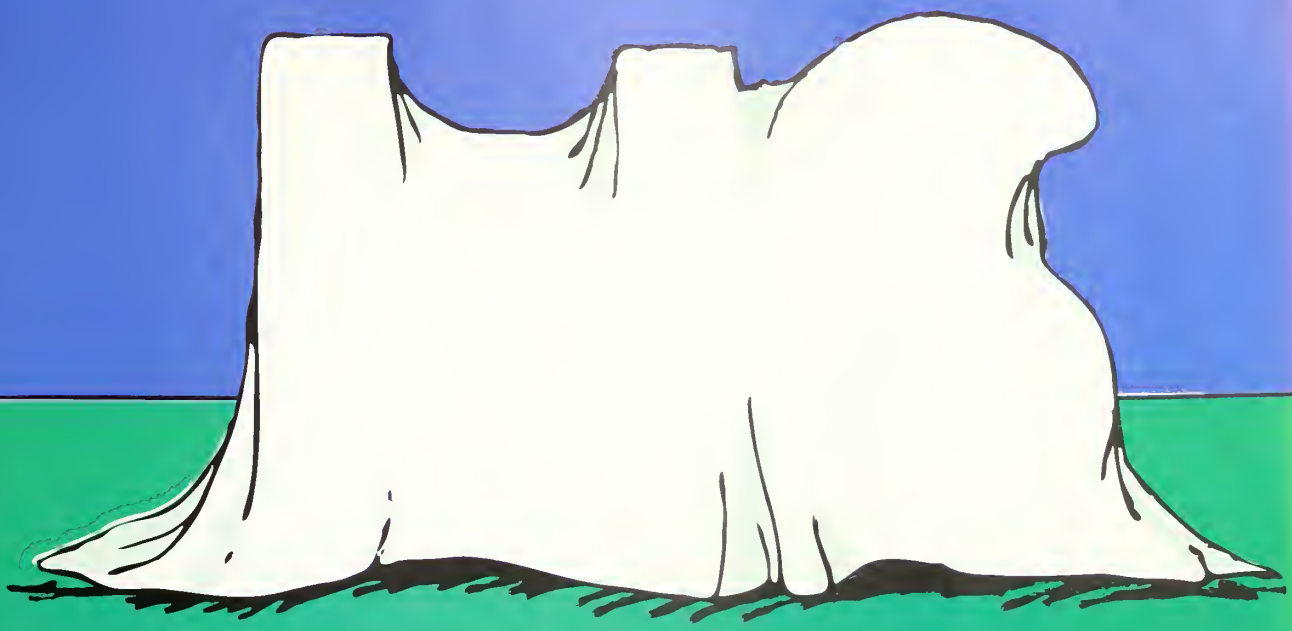
What do GPs think?

GPs have expressed mixed views over the switch. Despite BMA backing for POM status, the Royal College of General Practitioners warns that reclassification could see doctors swamped with extra work. "We are not convinced by the case for changing it to POM," says Dr James Kennedy at the RCGP. "It would have a big impact on doctors' workloads and NHS costs. For relatively minor illness, the trend is to try and enhance people's own ability to manage themselves."

What are the alternatives?

Crystal meth abuse could be better tackled by raising awareness of the problem among contractors, claims RPSGB president Hemant Patel. "In Australia they have launched pharmacy text messaging to prevent criminals buying products from several pharmacies." Canada has introduced a Methwatch programme, where pharmacy staff are trained to alert police over suspicious purchases.

Next week C+D asks the experts what they think about the switch ›



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Our new initiatives are under wraps for now, but look out for them coming your way soon.

Focused on U

UniChem

Your letters

Insulin comparisons don't add up

In the Clinical News section (C+D, March 24, p20) you summarised the results of a cost comparison of treatment with insulin glargine and insulin detemir published in a supplement of Current Medical Research Opinion.

The comparison showed cost reductions with the use of insulin glargine in both types of diabetes.

Although your summary of the trial reflected the published results, we need to draw readers' attention to the serious methodological flaw in this study, which makes the authors' conclusions arguable.

In general when a comparison is made between insulin preparations in terms of efficacy, safety or costs it is essential to compare identical insulin regimens, otherwise observed differences may be due to differences between patient groups and not between the insulin products.

In this case the authors compared insulin glargine and insulin detemir without fully considering that insulin glargine was more frequently used in combination with oral antidiabetics in a regimen called basal only therapy (BOT), while insulin detemir was prescribed significantly more often as part of an intensive basal–bolus therapy in patients with type 2 diabetes.

While BOT is typically used as an initial therapy, patients using basal–bolus therapy generally have more severe disease, and the cost of their treatment will usually be greater. The difference in treatment costs revealed by the study is therefore likely to be due to differences in the frequency of the insulin regimens required by the two groups.

Furthermore, the authors concluded that insulin glargine is also associated with lower costs in type 1 diabetes but again did not adjust the observed differences to take account of the known exposure of the basal analogue and baseline weight. Where they did make this adjustment the difference was not statistically significant.

Finally, this study investigates only prescription costs and not the impact of treatment on safety or efficacy endpoints such as glycaemic control, weight or hypoglycaemia. Any discussion of treatment cost that does not consider efficacy and safety seems to be irrelevant.

Peter Stella, medical adviser Novo Nordisk

We stand by our results

Dr Stella's principal criticism that we failed to adjust for different treatment regimens is unwarranted, as an examination of table 4 of the manuscript shows.

In type 1 diabetes, although it was true there was a non-significant difference in the mean volume of basal insulin prescribed, there was a highly significant difference in the volume of bolus insulin prescribed (+11 per cent for detemir; p=0.003). Regarding type 2 diabetes, the total mean insulin volume prescribed was significantly higher for patients treated with detemir in the following regimen types: basal–bolus, basal–bolus–oral, and basal–oral. The only group that did not reach statistical significance in this regard was the basal insulin only group, which was limited by small numbers (although even in this group, the magnitude of the difference remained the same as in other diabetes treatment regimens [+23 per cent detemir]).

The simple difference in dosing between glargine (once daily) and detemir (twice daily in most cases) could reasonably be expected to produce an observable difference in not only the amount of basal insulin prescribed, but also use of associated consumables.

However, this wouldn't explain why all the detemir basal-bolus cohorts appeared to receive more bolus insulin. This finding is consistent with many of the Phase III trials of detemir in which there was an increase in the mean bolus insulin requirement necessary to maintain normoglycaemia (consequently insulin detemir did not meet the US FDA criteria for non-inferiority over other basal insulins).

In a recent Novo Nordisk sponsored randomised study, people treated with detemir required 34 per cent more basal insulin than those treated with glargine.[1]

Contrary to Dr Stella's assertion, the cohorts were indeed well matched. The only statistically significant difference being in those with type 2 diabetes, where detemir-treated patients were slightly younger than those treated with glargine. If insulin detemir was administered to patients with more advanced type 2 diabetes, it would imply that they were older. And, all patients had never previously received basal analogue insulin.

Finally, the clinical outcomes of glycaemic control, weight change and hypoglycaemia for the study were described comprehensively in a sister paper published in the same peer-reviewed scientific supplement as the study referred to above.[2]

Thus, we unequivocally defend our conclusion that patients treated with glargine have lower antidiabetic prescribing costs than similar patients treated with detemir.

Dr Craig Currie and Dr Chris Poole Department of Medicine, 360° Research Ltd, School of Medicine Penarth, Cardiff University, Vale of Glamorgan

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Please include your name, job title if appropriate, your address and a contact number where we can reach you should we need to discuss the content of your letter.

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- For smokers who have used a single form of NRT before but need help to manage breakthrough cravings[3]

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Nicorette Patch Product Information: Presentation: Transdermal delivery system available in 3 sizes (30, 20 and 10cm²) releasing 15mg, 10mg and 5mg of nicotine respectively over 16 hours. **Uses:** Relief of nicotine withdrawal symptoms as an aid to smoking cessation. **Dosage: Adults (over 18 years):** Patients should stop smoking during treatment. The patch should be applied to the skin on the hip, upper arm or chest in the morning and removed at bedtime. Application should be limited to 16 hours per day. Initially one 15mg patch daily for 8 weeks. Dose should be reduced to 10mg for 2 weeks and then 5mg for a further 2 weeks. Adults who use NRT beyond 9 months should seek advice from a healthcare professional. **Adolescents (12 to 18 years):** As per adult, but duration of therapy should not exceed 12 weeks without consulting a healthcare professional. **Under 12 years:** Not recommended. **Contraindications:** Hypersensivity. **Precautions:** Erythema may occur. If severe or persistent, discontinue treatment. Unstable cardiovascular disease, diabetes mellitus, uncontrolled hyperthyroidism, phaeochromocytoma, generalised dermatological disorders, renal or hepatic impairment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response, to adenosine. Keep out of reach and sight of children and dispose of with care. **Pregnancy and lactation:** Only after consulting a healthcare professional. **Side effects:** Erythema, itching, urticaria, headache, nausea, vomiting, GI discomfort, dizziness, palpitations, reversible atrial fibrillation. See SPC for further details. **RRP (ex-VAT):** 15mg packs of 7: (£9.07). 10mg packs of 7: (£9.07). 5mg packs of 7: (£9.07). **Legal category:** GSL. **PL holder:** Pharmacia Limited, Ramsgate Road, Sandwich, Kent. CT13 9NJ. **PL numbers:** 0032/0292, 0293, 0294. **Date of preparation:** March 2007. **Nicorette Gum Product Information: Presentation:** Nicorette 4mg gum and Nicorette 2mg gum contain 4mg and 2mg of nicotine respectively in a chewing gum base. Original, Mint, Freshmint and Freshfruit flavours. **Uses:** Relief of nicotine withdrawal symptoms as an aid to smoking cessation. Used to help smokers ready to stop smoking immediately and also smokers who need to cut down their cigarette use before stopping. **Dosage: Adults (over 18 years):** No more than 15 pieces of gum should be used each day. Use when there is an urge to smoke. Patients smoking 20 or less a day should use 2mg gum. Those smoking more than 20 should use 4mg gum. Each piece should be chewed slowly for about 30 minutes. *Smoking cessation:* Patients should stop smoking during treatment. After up to 3 months ad libitum dosage, Nicorette gum use should be gradually reduced. Those who use NRT beyond 9 months should consult a healthcare professional. *Smoking reduction:* Use the gum between smoking episodes to reduce smoking. A quit attempt should be made as soon as the smoker feels ready but no later than 6 months. Professional advice should be sought if no reduction in 6 weeks or no quit attempt in 9 months. **Adolescents (12 to 18 years):** No more than 15 pieces of gum should be used each day. *Smoking cessation:* After 8 weeks ad libitum dosage, reduce gum use over 4 weeks. If not stopped by 12 weeks, a healthcare professional should be consulted. *Smoking reduction:* Only after consulting a healthcare professional. **Under 12 years:** Not recommended. **Contraindications:** Hypersensitivity. **Precautions:** Denture wearers, GI disease, unstable cardiovascular disease, diabetes mellitus, uncontrolled hyperthyroidism, phaeochromocytoma, renal or hepatic impairment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. Keep out of reach and sight of children and dispose of with care. **Pregnancy & lactation:** Only after consulting a healthcare professional. **Side effects:** Headache, sore mouth or throat, jaw-muscle ache, GI discomfort, hiccups, nausea, vomiting, dizziness, erythema, urticaria, palpitations, allergic reactions, reversible atrial fibrillation. See SPC for further details. **RRP (ex VAT):** 2mg gum (30) £3.25, (105) £8.89, (210) £14.82; 4mg gum (30) £3.99, (105) £10.83, (210) £18.24. **Legal category:** GSL. **PL numbers:** Original 2mg 00032/0248, 4mg 0032/0249; Mint 2mg 0032/0250, 4mg 0032/0251; Freshmint 2mg 0032/0283, 4mg 0032/0295, Freshfruit 2mg 15513/0136, 4mg 15513/0137. **PL holder:** Pharmacia Ltd. Ramsgate Rd, Sandwich, Kent.CT13 9NJ. **Date of preparation:** March 2007 **References: 1.** Puska P, Korhonen HJ, Vartiainen E, et al. Combined use of nicotine patch and gum compared with gum alone in smoking cessation: a clinical trial in North Karelia. Tobacco Control. 1995;4:231-35. **2.** Kornitzer M, Boutsen M, Dramaix M, et al. Combined use of nicotine patch and gum in smoking cessation: a placebo-controlled clinical trial. Prev Med 1995;24:41-47. **3.** Action on Smoking and Health. Guidance for Health Professionals on changes in the licensing arrangements for Nicotine Replacement Therapy. December 2005.

Date of preparation: March 2007

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C+D Clinical

Sticking point

C+D outlines the latest NHS childhood immunisation programme, and the vaccines it includes

Key points

- The childhood immunisation programme was updated last September, the main change being the introduction of a pneumococcal vaccine.
- The schedule protects against diphtheria, tetanus, pertussis, *Haemophilus influenzae* type b, polio, meningitis C, pneumococcal infection, measles, mumps and rubella.
- Pharmacists are ideally placed to counsel parents on the recent changes, offer reassurance and advice on the safety, efficacy and side effects of vaccines, and signpost reliable sources of information for anyone wanting more details.

Asha Fowells

Mollie Sanders, one of your regular customers, comes into the pharmacy and asks to speak to you. You notice that Mollie not only has her baby daughter Amelia in tow, but also appears to be pregnant – judging by the size of her bump, you guess she's about six months along.

Mollie explains that Amelia's first birthday is in a few weeks so she is due to have her second set of injections, which includes the MMR jab. Mollie is worried about the vaccine's safety and is thinking about asking the GP if her daughter could have the single injections to reduce the risk of autism. She also asks if the immunisation programme has been changed recently, as a woman from her postnatal group mentioned something along those lines and she wants to know what to expect when her second child is born in around three months' time.

Reflect

What would you say to parents asking if you could obtain single vaccines for their child rather than the combined MMR vaccine? Do you know at what age children should receive the pneumococcal vaccine? Are you aware of other changes to the immunisation schedule, introduced last autumn?

Plan

This article will inform you about the vaccines used, the timing and their safety, and will enable you to answer questions from the public.

Despite strong evidence that there is no connection between the MMR vaccine and autism, regular news stories still appear in the media

The College of Pharmacy Practice

This course (module 1403), in association with multiple choice questions being published in C+D May 5, provides one hour's continuing education

CPD

This article can help in the following CPD competencies: G1a, G1c, C1a, C1f, C2a, C2b. See www.tinyurl.com/194zu

Immunisation schedule

The NHS childhood immunisation programme changed last September, with the introduction of:

- A new vaccine to prevent against pneumococcal infection (and an accompanying catch-up programme).
- The addition of a *Haemophilus influenzae* type b booster injection during the second year of life.
- A new schedule for meningococcal serogroup C dosing.

The alterations were made on the recommendation of the Joint Committee on Vaccination and Immunisation (JCVI), the expert group set up in 1963 to provide independent advice to the UK governments' health departments. The full schedule can be seen in Table 1.

Table 1: UK vaccination schedule

Age	Vaccine(s)	Number of injections on that occasion
Two months	Diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b (DTaP/IPV/Hib) Pneumococcal conjugate vaccine (PCV)	Two
Three months	DTaP/IPV/Hib Meningococcal serogroup C (MenC)	Two
Four months	DTaP/IPV/Hib MenC PCV	Three
One year	Hib/MenC	One
13 months	Measles, mumps and rubella (MMR) PCV	Two
By school entry (between three years four months, and five years old)	DTaP/IPV MMR	Two
Before leaving school (13 to 18 years old)	Tetanus, diphtheria and polio	One

The routine vaccines

Diphtheria, tetanus, acellular pertussis, inactivated poliomyelitis and *Haemophilus influenzae* type b vaccine (DTaP/IPV/Hib)

- A suspension of diphtheria toxoid, tetanus toxoid, acellular pertussis, inactivated poliomyelitis and *Haemophilus influenzae* type b (conjugated to tetanus protein) is given at two, three and four months of age.
- Hib is given alone at one year.
- The combined vaccine minus the Hib element is given before school entry.
- A further vaccine containing tetanus, diptheria and polio is administered before the child leaves school.

Adverse effects Pain, swelling, redness and nodule formation (which usually disappears) at the injection site are common, and may occur more frequently after subsequent doses. Rare side effects include fever, high pitched crying and convulsions.

Pneumococcal conjugate vaccine (PCV) Given at two, four and 13 months of age, PCV contains polysaccharides from seven common capsular types of *Streptococcus pneumoniae* bacteria. A study has shown the vaccine to provide protection against pneumococcal meningitis, bacteraemia, pneumonia and otitis media, all of which children under two years are at particular risk of contracting.

Adverse effects The most commonly reported adverse reactions to PCV include swelling and redness at the injection site and mild pyrexia.

Meningococcal serogroup C conjugate vaccine (MenC) This vaccine is made from a capsular polysaccharide extracted from *Neisseria meningitidis* group C cultures and conjugated to a carrier protein to increase immunogenicity. Two doses should be administered at three and four months of age, and a reinforcing dose at 12 months.

Adverse effects Common side effects include pain, tenderness, swelling and redness at the injection site, as well as crying, irritability, drowsiness, impaired sleep, appetite loss, diarrhoea and vomiting.

Measles, mumps and rubella vaccine (MMR) These freeze-dried preparations contain live, attenuated strains of measles, mumps and rubella viruses.

The first dose should be given at 13 months of age, with a second before school entry. If the local risk of measles is high or the child is travelling to an endemic area, MMR can be given earlier than one year of age but residual maternal antibodies may reduce the response rate. In such cases, two further doses should still be given at the recommended times to ensure immunity.

Children with chronic conditions such as cystic fibrosis, congenital cardiac or renal disease and Down's syndrome are at particular risk of measles, and should be immunised. MMR is not recommended for severely immunosuppressed patients.

Adverse effects Following the first dose of MMR, malaise, fever and rash may occur, most commonly a week after immunisation and lasting two or three days. Adverse reactions are much less common after the second dose. Rarer events usually occur only in individuals who are susceptible to a particular component of the vaccine. Reactions to the measles fraction occur six to 11 days after vaccination and include febrile seizures, those to the rubella and mumps portions occur two to three weeks after injection, but sometimes up to six weeks post-immunisation, and include arthropathy.

There is still much in the media linking MMR with autism and bowel disorders, despite overwhelming evidence to the contrary. For example, a 2005 study demonstrated that there had been no increase in the incidence of inflammatory bowel disease since MMR vaccination was introduced in the UK.

Research considering a possible association between MMR and autism has shown – among other things – that there is no increased risk of autism in vaccinated children versus those who haven't had MMR, and that there is no correlation between the rate of autism and MMR vaccine coverage in either the UK or USA.

But scare stories continue to circulate and parents continue to ask for alternatives such as single injections. It is important to stress that as there are no single mumps or measles injections licensed in the UK, such products have not undergone the rigorous safety or efficacy tests required by the Medicines and Healthcare products Regulatory Agency. Furthermore, there is no country in the world that recommends single injections over the combined MMR vaccine.

Administration

All the above vaccines should be given intramuscularly into the thigh or upper arm to reduce the risk of localised reactions. The only exception applies to individuals with bleeding disorders who should receive vaccines by deep subcutaneous injection to reduce the risk of bleeding. If more than one injection is being given at a time, separate limbs or separate sites on the same limb at least 2.5cm apart should be used.

The vaccine name, batch number, injection site, and administering health professional should be noted in the child's health record.

There are few contraindications to the above vaccines other than those who have suffered an anaphylactic reaction to a previous dose or a certain component of a particular product. In such cases, specialist advice should be sought and the risk of not immunising the individual must be taken into account.

Minor illnesses, including colds and fevers, are not considered valid reasons for postponing immunisation. Health professionals may do so

if a child is acutely unwell, but this is usually to avoid confusing signs or symptoms of illness with any vaccine side effects.

Premature infants should have their immunisations at the appropriate chronological age, according to the schedule, and there is no evidence that they are at increased risk of adverse reactions.

Some non-routine immunisations

Tuberculosis This should be offered to all infants aged below one year who are either living in an area where the annual incidence of TB is 40 per 100,000 or greater, or who has a parent or grandparent who was born in a country with such an incidence rate.

The Bacillus Calmette-Guérin (BCG) live attenuated vaccine is the only one licensed for TB in the UK, and must be administered intradermally to the upper left arm. No other vaccine should be given in the arm for at least three months because of the risk of regional lymphadenitis.

Adverse effects Common side effects include headache, fever and a slightly enlarged lymph node. A small papule usually forms at the injection site, which will then ulcerate and subside over several weeks or months to a small flat scar.

Hepatitis B This injection is given intramuscularly to babies born to infected mothers within 24 hours of delivery. This is because the infection can be perinatally transmitted, putting babies at high risk of chronic infection with the virus. Appropriate vaccination can prevent more than 90 per cent of cases developing into the carrier state.

Further doses should be given at one and two months, and one year of age.

Adverse effects The vaccine is generally well tolerated, with the most common side effects being soreness and redness at the injection site.

Back to Mollie...

It is worth asking Mollie if her daughter Amelia has had her pneumococcal vaccine. Many children under two years will have had their primary course of injections without PCV, but a catch-up programme has been introduced to protect such individuals. If Mollie is unsure, you could ask her to bring in Amelia's child health record, often known to parents as "The Red Book".

It is important to address Mollie's concerns about the MMR vaccine. To get single vaccines, she would have to seek out a private clinic to administer unlicensed products. This would necessitate six instead of two injections, it would take longer for full immunity to be obtained – putting the child and others at risk of infection – and there would be a higher chance that the vaccination course would not be completed.

Another point worth mentioning is that all the vaccines used for the childhood immunisation programme are free of thiomersal. This mercury-based chemical was formerly used as a vaccine preservative and was linked to behaviour disorders, including autism, although several subsequent studies have found no such association.

You could explain the changes to the immunisation programme to Mollie, and provide her with a leaflet. She may need reassuring that it is considered safe to give so many injections to young babies, and that immunisation protects them – and others via herd immunity – against serious and often life threatening diseases. However, Mollie may want to ensure she has some infant paracetamol or ibuprofen at home in case either of her children develops a fever following vaccination, and you could counsel her on appropriate use.

Other side effects to warn her about include transient changes to bowel and feeding habits, increased sleepiness and general crankiness.

References and further reading:
• www.immunisation.org.uk
• www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Immunisation/fs/en
• Immunisation against infectious disease (the Green Book) is published by The Stationery Office or can be downloaded at www.dh.gov.uk/greenbook
• www.mmrthefacts.nhs.uk
• www.bnf.org.uk

Asha Fowells, MRPharmS, is clinical and continuing professional development editor, C+D.

Continuing Professional Development CPD

Act

• Revise how vaccines work and the various types in Chapter 1 of the Green Book (http://80.168.38.66/files/GB_Ch1_Immunity.pdf). There is a general vaccine review article at http://www.pjonline.com/pdf/cpd/pj_20060218_vaccines.pdf
• The adverse effects of vaccination are of considerable importance to patients and their carers. The article briefly covers this topic but you may need to know more. http://80.168.38.66/sitemap.php takes you to the site map of the NHS immunisation information service. From here you can access each vaccine and read a detailed account of the frequency and severity of their potential adverse effects.
• In providing advice to Mollie it would be helpful to give her a fact sheet on MMR. You can print one from the above site, together with information leaflets on all the vaccinations in the article.
• The first vaccination is given to a child at about two months old. What medicines can you counter prescribe to treat mild pyrexia, one of the most common adverse effects of vaccination?
• Could you provide Mollie with the single vaccines if she insisted that she wanted to follow that route? Would you?

Evaluate

• Do you now feel able to discuss, at least in outline, the reason for each childhood vaccination and risk:benefit ratio? How about the adverse effects? Could you recognise them so that you could reassure a mother who told you her child just had 'x' vaccination?
• The vaccinations required are extensive. Can you recall the list – or have it readily accessible – so that you could identify a child who had missed a vaccination?
• Can you defend the MMR triple vaccine? Would you feel able to persuade Mollie to have her child vaccinated with it?

Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the May 5 issue, which will cover this week's CPP-accredited module, together with those in the April 7 and April 14 issues.

These will cover:
• Alzheimer's drugs (1401)
• Cold sores (1402)
• Childhood immunisation (1403)

A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on 01732 377269.

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Introducing JANUVIA®(sitagliptin): The first in a new c

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ABRIDGED PRODUCT INFORMATION

Refer to Summary of Product Characteristics (SPC) before prescribing

Information about adverse event reporting can be found at www.yellowcard.gov.uk. Adverse events should also be reported to MSD Ltd (tel: 01992 467272).

PRESENTATION
100 mg film-coated tablet containing 100 mg of sitagliptin.

USES
'Januvia' is indicated in patients with type 2 diabetes mellitus to improve glycaemic control in combination with metformin when diet and exercise, plus metformin, do not provide adequate glycaemic control.

For patients with type 2 diabetes mellitus in whom use of a PPARγ agonist (i.e. a thiazolidinedione) is appropriate, 'Januvia' is indicated in combination with the PPARγ agonist when diet and exercise plus the PPARγ agonist alone, do not provide adequate glycaemic control.

DOSAGE AND ADMINISTRATION
One 100 mg tablet once daily, with or without food. Maintain the dosage of metformin or PPARγ agonist, and administer sitagliptin concomitantly. If a dose is missed, take as soon as the patient remembers. Do not take a double dose on the same day. ***Patients with renal insufficiency:*** no dosage adjustment required for mild renal insufficiency (creatinine clearance [CrCl] ≥50 ml/min). Not recommended in patients with moderate or severe renal insufficiency. ***Patients with hepatic insufficiency:*** no dosage adjustment necessary for patients with mild to moderate hepatic insufficiency. 'Januvia' has not been studied in patients with severe hepatic insufficiency. ***Elderly:*** no dosage adjustment necessary. Exercise care in patients ≥75 years of age as there are limited safety data in this group. ***Children:*** not recommended in children below 18 years of age.

CONTRA-INDICATIONS
Hypersensitivity to active substance or excipients.

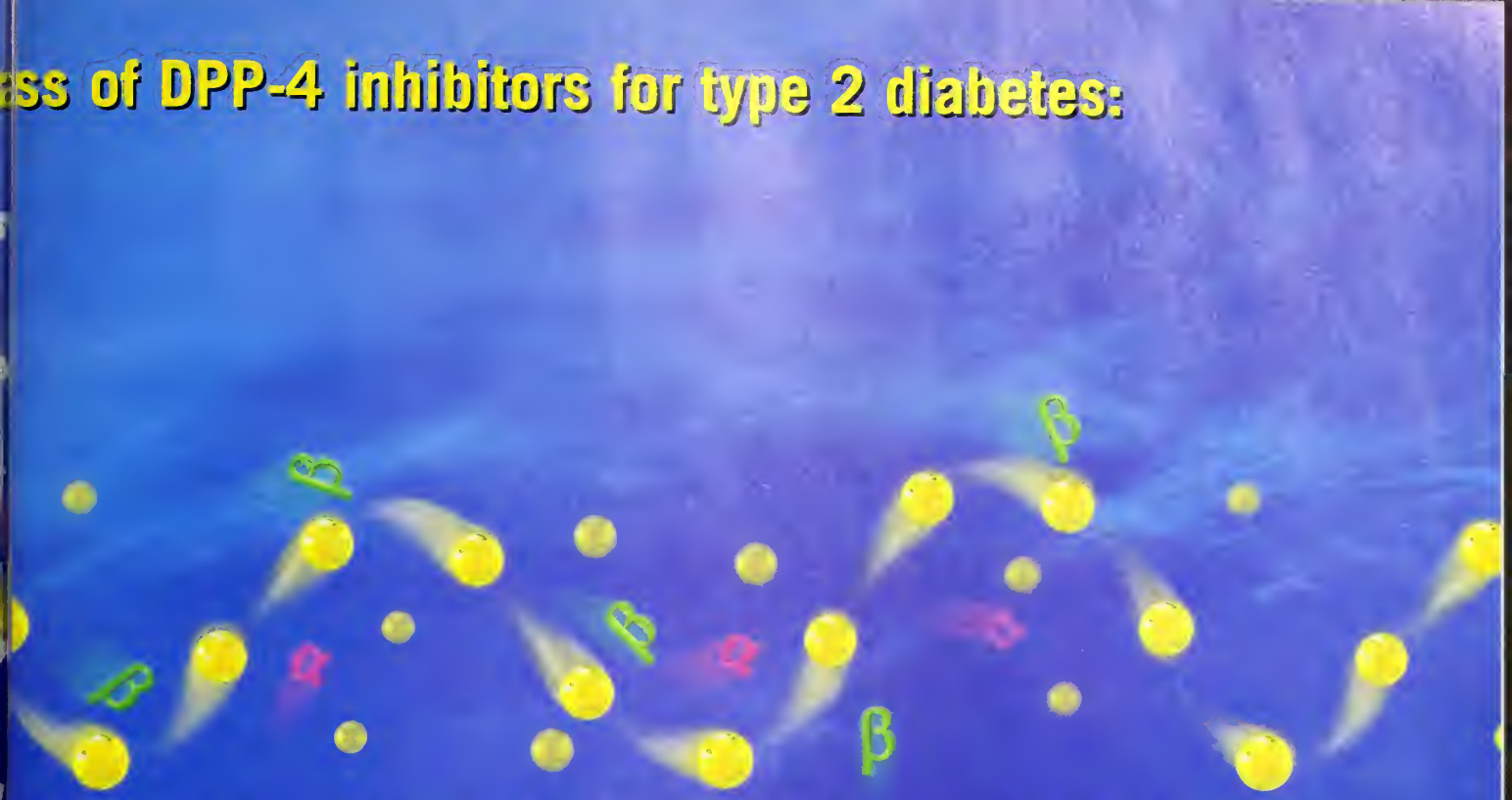
PRECAUTIONS
General: do not use in patients with type 1 diabetes or for diabetic ketoacidosis. ***Hypoglycaemia:*** in trials of sitagliptin as monotherapy, or as part of combination therapy with metformin or pioglitazone, rates of hypoglycaemia reported with sitagliptin were similar to rates in patients taking placebo. Use of sitagliptin in combination with agents known to cause hypoglycaemia, such as sulphonylureas or insulin, has not been adequately studied.
Drug interactions *Effects of other medicinal products on sitagliptin* Low risk of clinically meaningful interactions with metformin and ciclosporin. Meaningful interactions would not be expected with other p-glycoprotein inhibitors. The primary enzyme responsible for the limited metabolism of sitagliptin is CYP3A4, with contribution from CYP2C8. *Effects of sitagliptin on other medicinal products Digoxin:* sitagliptin had a small effect on plasma digoxin concentrations, and may be a mild inhibitor of p-glycoprotein *in vivo*. No dosage adjustment of digoxin is recommended, but monitor patients at risk of digoxin toxicity if the two are used together. *Pregnancy and lactation:* Do not use during pregnancy or breast-feeding.

SIDE EFFECTS
Refer to SPC for complete information on side effects
In clinical trials in over 2,700 patients, the rate of discontinuation due to adverse experiences considered drug-related was 0.8 % with 100 mg per day and 1.5 % with other treatments. No adverse reactions considered as drug-related were reported in patients treated with sitagliptin occurring in excess (>0.2 % and difference >1 patient) of that in patients treated with control.

04-08 JAN.06.GB.32166.Jd

Date of preparation: April 2007

ss of DPP-4 inhibitors for type 2 diabetes:



Oral incretin enhancement in clinical trials:

- Substantial glucose control through a physiologic mechanism of action[1,2]
- Low incidence of hypoglycaemia and low risk of weight gain[2]
- Oral once-daily treatment

Add-on to metformin or glitazone monotherapy for patients who need additional control

Combination with metformin: Common (≥1/100, <1/10): nausea; *Uncommon (≥1/1,000, <1/100):* somnolence; upper abdominal pain, diarrhoea; blood glucose decreased, anorexia, weight decreased. ***Combination with a PPARγ agent (pioglitazone):*** *Common (≥1/100, <1/10):* hypoglycaemia, flatulence, peripheral oedema. In addition, in studies of sitagliptin 100 mg alone compared to placebo, adverse reactions considered as drug-related reported in patients treated with sitagliptin in excess (>0.2 % and difference >1 patient) of that in patients receiving placebo are headache, hypoglycaemia, constipation, and dizziness. Also, adverse experiences reported regardless of causal relationship to medication and more commonly in patients treated with 'Januvia' included upper respiratory tract infection, nasopharyngitis, osteoarthritis and pain in extremity

PACKAGE QUANTITIES AND BASIC NHS COST 28 Tablets: £33.26

Marketing Authorisation Number EU/1/07/383/014

Marketing Authorisation Holder Merck Sharp & Dohme Limited
Hertford Road, Hoddesdon, Hertfordshire EN11 9BU, UK

POM **Date of review of prescribing information: April 2007**

References:
1. JANUVIA Summary of Product Characteristics.
2. Nauck M, Meininger G, Sheng D, et al for the 024 Study Group. Efficacy and safety of the dipeptidyl peptidase-4 inhibitor, sitagliptin, compared to the sulfonylurea, glipizide, in patients with type 2 diabetes inadequately controlled on metformin alone: a randomized, double-blind, non-inferiority trial. *Diabetes Obes Metab.* 2007; 9:194–205.

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NEW
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A Practical Approach...

Mrs Kent has asked to see pharmacist David Spencer at the Update Pharmacy.

"You know who I am, don't you?" she asks when David meets her in the consultation area.

"Of course I do," replies David. "You regularly collect your mother's prescriptions for her. What can I do for you today?"

"I want you to put mother's medicines in those timed dosage packs in future, please."

"May I ask how you know about those and why you want them?" says David.

"I've just seen that mother's neighbour has them and I think she ought to have them too. After all, we pay enough into the NHS, and I want what we're entitled to."

"Do you know why her neighbour has them?"

"She's elderly and she's getting rather confused and forgetful. Having her medicines like that helps her take them at the right time."

"Is your mother forgetful too?" David asks.

"No, luckily, she's still as sharp as a pin."

"So, why do you want her to have the packs?"

"Well, she's virtually blind."

"So you think that they would help her to take her medicines more easily?"

"Oh no," replies Mrs Kent. "She can't see well enough to take her medicines herself. I have to give them all to her. It would just make things a lot easier for me."

"I don't think I could supply them on that basis," David says.

"Alright," retorts Mrs Kent. "I'll see her GP and get him to make you. You've got to under the law, you know."

Questions

1. Will David have to supply Mrs Kent's mother's medicines in monitored dosage packaging (MDP), either under "the law" or his NHS contractual obligations?
2. Can Mrs Kent's mother's GP make David supply the medicines in the packs?
3. If David does supply in these packs, is he entitled to extra payment and, if so, how much?

Answers →

CPD

This article can help in the following CPD competencies: C1c, C3b, C3e, C5a. See www.tinyurl.com/194zu

Antidepressant benefits may outweigh risks in children

The debate over antidepressant treatments in children is likely to reopen after a review found the benefits may outweigh the risks in those with depression or anxiety disorders.

In 2003, fears that antidepressants increased suicide in children and adolescents prompted the UK Committee on Safety of Medicines to advise doctors against prescribing any SSRI in under 18s with the exception of fluoxetine.

The latest review analysed data from 27 randomised controlled trials involving paediatric use of antidepressants for major depressive disorder (MDD), obsessive–compulsive disorder (OCD) and non-OCD anxiety disorders, including new trials not included in previous analyses.

It found a small increased risk of suicidal ideation or suicide attempt after treatment, but it was not significant. The pooled random-effects risk differences of suicidal ideation or suicide attempt were less than 1 per cent and there were no successful suicides reported in the trials. Evidence of efficacy was found in all three indications, particularly in non-OCD anxiety disorders.

The researchers concluded that the strength of evidence supported cautious and well-monitored use of antidepressant medications.

For more information:
JAMA 2007; 297: 1683-96

No discernible benefits to new insulin

A Cochrane review of long-term trials comparing long-acting insulin analogues with the older NPH insulin has concluded that no unambiguous evidence of clinical benefits for the new treatments yet exists, and that they should be used cautiously.

In the review, insulin glargine and insulin detemir were almost identically effective to NPH insulin in controlling long-term metabolic control as measured by HbA_{1c}.

Fewer people experienced symptomatic overall or nocturnal hypoglycaemic episodes using the newer insulins, but no conclusive information on late complications or on possible differences in fatalities yet exists.

Also, it was not possible to draw firm conclusions on the new insulins' effects on quality of life or cost effectiveness.

For more information:
www.cochrane.org

Aspirin lowers cancer risk

Long-term daily use of adult-strength aspirin may be associated with modestly reduced overall incidence of cancer. A large study in the USA of 325mg per day or more of aspirin found that daily use for five or more years was associated with roughly 15 per cent fewer cancers in men compared with no use.

The lower incidence was a result of 30 per cent lower colorectal cancer incidence and 20 per cent lower prostate cancer incidence.

For more information:
J Nat Canc Inst 2007; 99: 608-15

A Practical Approach... this week's answers

1. Under the Disability Discrimination Act 1995 (DDA) pharmacists, in common with all other organisations or businesses providing services to the public, have to take "reasonable steps" to provide auxiliary aids if it helps a disabled person to use their services. For pharmacists this may includes providing medicines in MDP, if necessary. What is "reasonable" is not defined in the DDA and pharmacists must assess whether the patient is disabled under the terms of the Act and, if so, what aids are necessary. In this case, although the patient is disabled, providing medicines in MDP would not help her to take her medicines more easily and would just be for the convenience of her daughter. David is therefore under no legal obligation to supply the medicines this way, nor does he have any NHS contractual obligation in this case. However, he may decide to do so if he feels it is ultimately in the patient's best interests or just to retain goodwill.
2. A request from the patient's GP may increase the pressure on David to supply in MDP, but cannot oblige him to do so. Readers may refer to the guidance on the PSNC website on how doctors cannot direct pharmacies to dispense 28-day prescriptions at seven-day intervals.
3. David would not receive any extra payment for supplying MDP in this situation. When the new community pharmacy NHS contract was introduced, funding of 5.5p per prescription item was included to help meet costs of complying with the DDA.

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In brief

Eating less salt can cut cardiovascular disease risk by a quarter and fatal heart disease by a fifth, a study of more than 3,000 people has shown. In the US trial, participants who all had hypertension or pre-hypertension reduced their salt (sodium) intake from about 10g to around 7g a day.
BMJ, published online April 20, 2007

The Scottish Intercollegiate Guidelines Network has published a draft of its forthcoming guidelines on the control of pain in patients with cancer.
http://tinyurl.com/28oxdt

Pooled results from five studies have shown orlistat significantly reduces both weight and improves key cardiovascular risk factors including high blood pressure, glycaemic control and lipid profile in overweight patients with both type 2 diabetes and hypertension.

Researchers have confirmed the importance of flu vaccination among those at high risk of cardiovascular events. Analysis of deaths between 1993 and 2000 in Russia showed that a peak of acute heart attack and chronic ischaemic heart disease deaths coincided with the influenza epidemic. During epidemic weeks, the risk of heart attack increased by 30 per cent and risk of CHD death increased by 10 per cent.
Eur Heart J, published online April 17, 2007

Teva UK has launched the first range of generic cabergoline tablet treatments in strengths from 0.5 to 4mg. It has also produced a leaflet explaining that although patients will notice the packaging may have changed, the active ingredient is the same.

The PREVAIL study published in The Lancet has shown a reduction in VTE events of 43 per cent in stroke patients treated with enoxaparin compared with unfractionated heparin.

An information website has been set up to inform patients concerned about changes to their inhaler, following the withdrawal of inhalers containing CFC-based propellants.
www.ourasthma.com

The Prescription Cost Analysis for England during 2006 has been published at the PSNC website. It gives the number of items, net ingredient costs (NIC) and average NIC per prescription for products dispensed in the community broken down by individual preparations and by category.psnc.org.uk

A survey by the ABPI has revealed a total of 951 compounds in Phase I, II or III clinical trials in 2006 – many more than the 561 candidates in development when the ABPI published its last survey five years ago.

Pharmacist training could cut heart failure admissions

Medicines use reviews and advice provided by community pharmacists are not effective in reducing hospital admissions of patients with heart failure, say researchers writing in this week's issue of the BMJ.

Noting that specialist nurse-led interventions have been shown to be effective, the authors concluded that pharmacists may need additional training in this area.

Some 5 per cent of hospital admissions are due to heart failure, and policy makers are said to be keen for pharmacists to contribute to reducing this figure.

The researchers randomised 293 patients with heart failure to intervention and control groups.

They found that although patients were very satisfied with the educational and symptom

self-management support provided by pharmacists, the interventions did not reduce hospital admissions.

Some 30 intervention patients died compared with 24 control patients.

Steroids benefit in acute sinusitis

Intra-nasal corticosteroids (INCS) have modest benefit in the treatment of acute sinusitis, say Cochrane researchers.

Analysis of four randomised placebo-controlled trials of 1,943 participants treated for 15 or 21 days showed 73 per cent of patients prescribed steroids had resolution of symptoms versus 66.4 per cent in the placebo group.

Higher doses of steroids had a stronger effect and no significant adverse events were reported.

There were no significant differences in rates of recurrence between the treatment groups or for those receiving higher doses.

"For acute sinusitis confirmed by radiology or nasal endoscopy, current evidence is limited, but supports the use of INCS as a monotherapy or as an adjuvant therapy to antibiotics," the review concluded.

"Clinicians should weigh the modest but clinically important benefits against possible minor adverse events when prescribing therapy," they added.

For more information:
www.cochrane.org

Sitagliptin diabetes treatment launched

Sitagliptin has been launched by Merck Sharpe & Dohme as the first of a new class of DPP4 inhibitor treatment for type 2 diabetes under the brand name Januvia.

The treatment is indicated as an add-on to either metformin or a thiazolidinedione when diet, exercise and either therapy alone does not provide adequate glycaemic control.

Contraindications include type 1 diabetes and diabetic ketoacidosis; also, patients with moderate to severe renal insufficiency should not be treated with sitagliptin, as experience is limited. Trials have revealed that sitagliptin is well tolerated, and is not associated with increases in hypoglycaemic incidences or with weight gain.

In normal patients, eating food releases gut hormones called incretins that cause the pancreas to produce insulin and to reduce glucose release by the liver. This effect is greatly reduced in type 2 diabetes.

The new treatment increases levels of incretin molecules by inhibiting the action of DPP4, which removes the active portion of the incretin molecules, and keeps incretin levels in check in non-diabetic people.

Increased incretin levels due to DPP4 inhibition then cause the patient to produce more of their own insulin and reduces glucose release by the liver.

The treatment costs £33.26 for a 28-day blister pack of film-coated tablets; the Pip code is 326-8281.

Have your say

We'd like **you** to be part of C+D's new Clinical Advisory Panel, which will help shape our clinical content and ensure it meets the needs of pharmacists. Email clinical editor Gavin Atkin at gmatkin@cmpmedica.com today.

With global warming, millions are suffering from hayfever.[1-5] Changing times call for fast, effective measures

Global warming is a growing challenge. Early arrival of spring and longer plant growing periods mean there's even more pollen in the air to aggravate hayfever sufferers. For fast, effective hayfever relief, recommend an allergy expert. No other brand treats more allergies than Piriton.

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- mould spure allergies

Also relieves the itchy rash of chickenpox

30

chlorphenamine

Piriton Allergy Tablets Product Information. Presentation: Tablets containing 4 mg chlorphenamine maleate. **Uses:** Symptomatic relief of chickenpox itch and allergic conditions including hayfever. **Dosage and administration:** *Adults:* 1 tablet every 4-6 hours. *Children aged 6-12:* ½ tablet every 4-6 hours. **Contraindications:** Hypersensitivity. Concurrent or recent treatment with MAOIs. **Precautions:** May increase effects of alcohol. May affect ability to drive and use machinery. Use with caution in prostate, respiratory, liver, cardiovascular and thyroid disease; epilepsy, glaucoma and other eye conditions. **Side effects:** Sedation. Less commonly, gastrointestinal disturbances, blurred vision, headaches, urinary retention, dry mouth, muscular incoordination, jaundice, cardiovascular disturbances, chest tightness, dizziness, blood dyscrasias, allergic reactions, tinnitis. Children and the elderly are more prone to the neurological anticholinergic effects. **Pregnancy and lactation:** Consult doctor before use. **Legal category:** P. **Product licence number:** PL 00036/0091. **Product licence holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** 30 tablets £3.15. **Date of last revision:** October 2004. PIRITON,® PIRITON® Petal Device are registered trade marks of the GlaxoSmithKline group of companies.

References: **1**. National statistics. The health of children and young people. http://www.statistics.gov.uk/children/downloads/asthma.pdf **2**. http://news.bbc.co.uk/1/hi/health/2721375.stm **3**. Beggs JP, Bambrick HK. *Environ Health Perspect* 2005; **113**: 915-919 **4**. Beggs JP. *Clin Exp Allergy* 2004; **34**: 1507-1513 **5**. Emberlin J. The national pollen and aerobiology research unit. http://www.pollenuk.co.uk/News/jesummary.htm **6**. Vitousek PM *et al. Ecology* 1994; **75**: 1861-1876 **7**. Parikh A, Scadding GK. *BMJ* 1997; **314**: 1392 **8**. Sparks TH, Menzel A. *Int J Climatol* 2002; **22**: 1715-1725 **9**. Bousquet J *et al. J Allergy Clin Immunol* 2001; **108** (Suppl S): S147-S334 **10**. Mason P. *The Pharmaceutical Journal* 2003; **270**: 443-445 **11**. Sheikh AS et al. *BMJ Clinical Evidence* 2004; **11**: 694-709 **12**. Allergy UK http://www.allergyuk.org/allergy_whatis.aspx

Pharmacy Champions

Pharmacists leading the way

Name
Ivo Vincour

Pharmacy
Day Lewis Pharmacy, Billericay, Essex

What has he done?
Set up a number of services with the emphasis on care in the community

"Communicate with your customers and explain to them what you're trying to achieve"

What have you set up?

We offer a free prescription delivery and collection service. We treat each customer as an individual and give them a personal touch. Nothing is too much hassle. If an elderly patient needs a medicine, we will deliver it to them the next day. We will also collect their prescription from the GP surgery to save them the trip. Our driver calls at 24 homes each day. Other pharmacies in the area deliver only once or twice a week and they charge a fee. Our prescription count has increased considerably since we started offering the service.

We have carried out at least 180 MURs and supply monitored dosage systems to at least 40 patients, which has helped them become more compliant. We also supply a nursing home in Brentwood.

In addition, we run a smoking cessation service, needle exchange and methadone dosing.
We were Day Lewis's branch of the year in 2006.

Nominate your Pharmacy Champion:
Telephone 01732 377688
or email chemdrug@cmpmedica.com

What has been the high and low point of setting up the service?
For nearly three years I've been working in a small close-knit community and the customers all know me. It can take me 10 minutes just to get across the road because they stop me to chat and ask questions. They respect me, I give them good advice and they take heed. It makes it all worthwhile. The low point is the hard work and all the bureaucracy. It's a juggling act to get everything done.

What has been the reaction of GPs and other health professionals?
The GPs are really quite good. Before my team started here, the relationship between the local GPs and the pharmacy had started falling apart because they always dealt with locum pharmacists. Now they support us and we help them out when we can.

Do you have any advice for others?
Communicate with your customers and explain to them what you're trying to achieve. There may be teething problems because people don't like change, but they'll soon see the benefits. Treat them the way you'd like to be treated. Give everything 100 per cent effort – all the time. It's easy to do this if you're doing a good job because the compliments will come.

Why do you think you have been successful?
It's all about attitude and work ethic. We've been together as a team for more than two years and it's made us so popular with the locals. Billericay has an elderly population and often we're the only people they speak to all day.

"Treat each customer as an individual and give them the personal touch"

Has offering the service given you greater job satisfaction?
Definitely, because I can see the results. I have one patient who is schizophrenic. When I first saw him he was on the streets and displaying obsessive-compulsive behaviour. Since we put him on a monitored dosage system his life has changed.

What are your hobbies and interests outside work?
I like to keep fit so I go to the gym. Last year I ran the Berlin Marathon, which was amazing. I also do a lot of travelling. This job was meant to be part of a working holiday, but it's turned out to be more work than holidaying. I took three months off in 2005 and I hope to repeat it.

If you were in charge of the pharmacy profession for just one day, what would you change?
I'd reduce the amount of paperwork. I'd also switch more medicines from POM to P – for example, antibacterial creams. It's frustrating when I know that's what a patient needs and cannot sell it over the counter. It seems ridiculous that I can sell simvastatin without having a clue what the patient's cholesterol level is, but I can't sell a cream when I know what the problem is.

Ivo Vincour and his team, including pharmacy technician Michael Addo, below left, and sales assistant Veronica Quarrell, below right, have been together for two years and are popular with the locals

Products in brief

Flogging a dead louse

Full Marks Solution head lice treatment is now available in a 300ml family pack. The brand will be supported by a national TV advertising campaign from April 30 until late May. In a departure from traditional head lice treatment ads, the creative features a louse character and the catchphrase: "From head louse to dead louse in just 10 minutes."
Price and Pip code: £14.99/300ml, 325-7714; SSL International, tel: 0870 122 2689

Ymea adds smaller pack

The Ymea menopause supplement from Chefaro is newly available in packs of 32 capsules. Joining the existing 64 size on shelf, the new pack is expected to encourage trial of the product. Ymea contains extracts of soya, hops and bitter melon, said to help maintain harmony and balance before, during and after the menopause.
Price and Pip code: £6.99/32, 326-2110; Chefaro, tel: 01480 421808

Salty launch from Ahava

The Pure home spa range from Ahava has been extended by bath salts in two fragrances. Placid Bath Salts uses Syringa-Green Apple fragrance to relax the spirit and calm the mind, says Ahava, while softening the skin and easing muscle tension. The mandarin and cedarwood scented Revival Bath Salts are said to enliven the senses and revitalise the spirit. Also new are 1kg and 2x250g packs of Dead Sea bath crystals. Price: Bath salts £10.50/ 500g; Dead Sea crystals £12.95/1kg, £10/2x250g; Ahava UK, tel: 01452 864574

Wartner sports a new look

Verruca and wart treatment Wartner from Chefaro is sporting new-look packaging.

The new packaging was designed to produce clear differences between the wart and verruca variants. It generated positive consumer responses including a better understanding of the treatment process, said Chefaro.

In addition, May 1 sees the launch of the Wartners Sole Matters healthy feet campaign, which is backed by Society of Chiropodists and Podiatrists and led by Olympic swimmer Karen Pickering.

Wartner Verruca Remover uses a form of cryotherapy to kill the virus and remove the verruca by freezing it.

Price: £12.95 verucca, £11.95 wart

Product info:
Chefaro
Tel: 01480 421808

New look for Cuprofen

Analgesic brand Cuprofen has been redesigned for a vibrant, up-to-date feel, says SSL. The P product claims to be the most recommended analgesic brand in pharmacy.

Stablemate Paramol is claiming to be the fastest growing analgesic in pharmacy, with growth of 18.9 per cent year on year (IRI 52 w/e Feb 24, 2007). TV advertising has been running this month and a second burst will follow later in the year.

Syndol is set to benefit from a TV campaign running from May 1 until June 10, bringing SSL's promotional spend on its pharmacy-only analgesic portfolio to £2 million.

Product info:
SSL International
Tel: 0870 122 2689

Seabond sticks with campaign

Seabond denture fixative seals are reaping the rewards of a second burst of national TV advertising, which continues until the end of the second week of May in all areas.

Combe International has increased its spend to £1 million, as part of an £8m investment in support for key brands throughout 2007.

The tagline 'An all-round fit you can really feel' is reinforced on updated packaging for Seabond, which is available for both upper and lower dentures. The wafer-thin seals contain an added breath freshener and are available in flavour-free Original and Fresh Mint varieties.

Product info:
Combe International
Tel: 020 8680 2711

Delectable sweet launch

Halal Scrumptious Marshmallows from Scrumptious Sweets are suitable for Muslims as well as sufferers of food intolerances and allergies, being free of gluten, nuts, soya, alcohol, fat and milk.

Scrumptious Sweets is a new company created by Saida Ebrahim who recently won the Peterborough Enterprise Programme's Best Business Idea 2007 for her plan to import specialist confectionery to the UK.

Price: £1.49/100g

Product info:
Scrumptious Sweets
Tel: 01733 569175

The Care Summer skin range.
TLC that looks after you as well as your customers.

Sunburnt, dry or chapped skin? Minor burns and abrasions?
The Care summer skin range includes Calamine Lotion, Aqueous Calamine Cream, Aqueous Cream and Antiseptic First Aid Cream. It's a range of TLC your customers will love you for.
For more information about the Care skincare range, please call 01484 848 200 or ask your local sales representative.

Care+™

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C+D's two minute interview with ...

Ben Peters, brand manager for Nicorette

Who buys Nicorette?
There are two groups: smokers who want to give up immediately and those who want to cut down gradually.

Why stock Nicorette?
Smoking is a personal habit so smokers need choice to tailor their quit attempt.

Nicorette offers the widest range of options, providing smokers with a way to give up that best suits their lifestyle. They may want to give up gradually, in which case the gum and inhalator products are good options. The range includes some pharmacy-only lines so pharmacies can offer the widest set of options, backed up by advice and knowledge.

In the run up to 'Smokefree' in England on July 1, more smokers will be looking to quit or reduce the number of cigarettes they smoke. Of the 11 million smokers in England and Wales, four million are planning to change their smoking habit. Of these, 45 per cent see the legislation as a positive catalyst.

It's the pharmacist's job to be there when needed; interest is certain to grow as we approach July 1. Some smokers will plan ahead while others will react to the change. Pharmacists can expect to see a high throughput in the run-up to and around July 1.

The announcement in the Budget that VAT will be reduced on stop smoking products from July 1 is a clear signal from the government to support smokers wanting to quit. Nicorette and other products will become more available to more people.

Nicorette's online support, Active Stop, offers personalised psychological support on the internet and via text messages to help smokers through their quit attempt. This is a useful resource for pharmacists as quitters are likely to lapse and this offers support while the patient is not with the pharmacist.

Refer Nicorette customers to the site and book a follow up appointment in a couple of weeks. The site will help handle the high volumes of quitters who need behavioural support during the introduction of the Smokefree legislation.

How can pharmacies sell more?
By providing accessibility, especially to GSL formats in self-selection areas and combining this with advice and education on which formats to use.

It is especially important to draw attention to the unique 'P' formats that are also available, such as the inhalator and nasal spray. Quitters often stop their quit attempt quite quickly so support helps achieve positive outcomes.

Counter staff need to know about the category and make sure you have adequate stock available so you don't run out at key times.

Are there any brand innovations in the pipeline? Or a dream innovation you'd like to see?
New this year is Nicorette Fresh Fruit gum. It has a soft centre and studies have shown it to be the best tasting fruit nicotine gum available. As taste is key to compliance we see this as a great addition to the range.

In addition we are endorsing a special way of using NRT products in combination. Suitable for those who have tried monotherapy and failed, the method has been endorsed by experts. It's not something that will appear on pack but is just a method healthcare professionals will be able to recommend in consultations with smokers. My dream innovation would be a personal coach for Nicorette users or something that would make quitting as cool as some people currently regard smoking.

Who would be your fantasy celebrity spokesperson?
Lance Armstrong – he's had a personal battle with cancer and reached the highest standard in his sport, combining science and willpower to achieve his goal.

Interested in appearing in C+D's **one minute brand manager interview?** Contact Lesley Ribbens on 01732 377600 or email lribbens@cmpmedica.com

Seasonal shaving promo

Gillette has launched seasonal packs of two of its women's shavers. Promotional packs of Venus Vibrance and Venus Divine offer consumers the chance to buy a pack of blades and get the razor half price.

The packs are expected to appeal to women preparing for the holiday season, says Gillette.

Product info:
Gillette
Tel: 01932 896000

Products advertised on TV next week

Buscopan: GMTV
Deep Heat: All areas except GMTV, five
DulcoEase: C4, GMTV, Sat
Frontline: GMTV, Sat, five
Gaviscon Double Action: All areas
Haliborange Omega-3: GMTV, Sat
HemoClin: GMTV, Sat
Kwai: C4
Lyclear SprayAway & Repellent: GMTV, Sat
Nivea Light Feeling Lotion: all areas except GMTV
Seabond: All areas
Zovirax: All areas
PharmaSite for next week: Bazuka – windows, Bazuka – in-store, Allergan Refresh – dispensary
Pharmacy channel: elave, Complan, Piriton

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Is their medication ending up where it should be?

Dysphagia, or swallowing difficulty, is a much more widespread problem than you might think.[1] It leaves many people, especially the elderly, struggling to swallow their medicine and often leads to it being thrown away.

Such non-compliance has serious consequences in that it can lead to poor outcomes, hospitalisation or even patient death.[2] It also costs the NHS over a billion pounds a year in wasted medicines and the costs associated with adverse clinical outcomes.[3]

That's why it makes sense to give people who can't swallow solid medicines a more appropriate formulation such as a liquid - and the sooner this is done the greater the difference it can make in terms of improved compliance and patient welfare.

Rosemont specialise in liquid medicines offering solutions across a wide range of therapeutic areas.

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References:
1.Strachan I, Greener M. Medication-related swallowing difficulties may be more common than we realise, *Pharmacy In Practice* December 2005. 2. Richard Griffith, Medication Management and the law 2 – Residents With Medication Related Dysphagia 2006. 3. Greener M. *JME* 2006; 9: 27-44.

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Soothing the itch

In part two of a feature about childhood ailments, **Sarah Purcell** speaks to experts in the field of eczema to find out what pharmacists can do to increase the use of emollients

If used correctly, one in four children with eczema could control their condition with emollients alone. So why are they so under-used and how can pharmacists help to change this?

In the 1940s just 5 per cent of children suffered from eczema, but today it has soared to around 20 per cent. The most common skincare condition affecting children, you can expect to see many parents coming to your pharmacy to ask for advice on treatments, and with GPs becoming ever more time-pressured this is an area where pharmacists could take on a greater role in future.

Dr Michael Cork, head of academic dermatology at the University of Sheffield, runs an eczema clinic at Sheffield Children's Hospital. He has carried out studies into how eczema treatments are used by parents and the effect they have on the child's condition.

"We found that few parents were using enough emollients and those who were didn't use sufficient quantities to control the child's eczema," says Dr Cork. "We found that one in four parents weren't using emollients at all and those who did used only 100g per week – we recommend 500g a week. And knowledge on how and when to apply the creams was poor too."

At Dr Cork's clinic, parents were given a demonstration on how to use the creams properly, which led to an 80 per cent increase in their use. They found that 25 per cent of children's eczema could be controlled with emollients alone and that there was an 89 per cent decrease in the severity of a child's eczema when emollients were used correctly.

Why emollients are so effective

Emollients form an oily layer over the surface of the stratum corneum and this traps moisture underneath, which then passes back into the corneocytes, filling them with water. As the corneocytes swell up, the cracks between them are closed up and they provide a more effective barrier against irritations and allergens. Emollients also pass into the upper layers of the stratum corneum and keep skin cells hydrated.

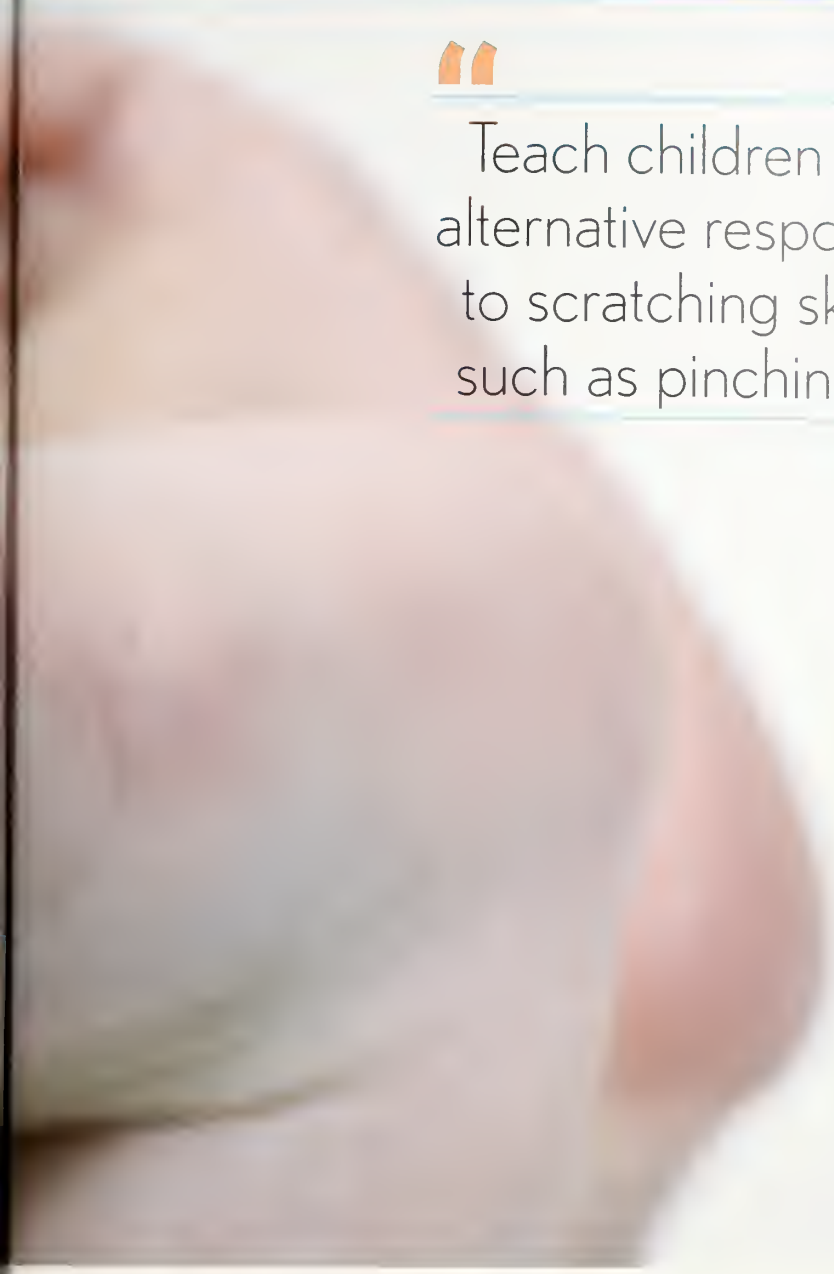
"To have maximum effect on the defective skin barrier in atopic eczema, patients should be treated continuously with complete emollient therapy," says Dr Cork.

So why are they so under-used? "I believe it all comes down to education – parents just don't understand how important emollients are in the treatment of their child's eczema," says Dr Susan Mayou, consultant dermatologist at the paediatric department of Chelsea & Westminster Hospital, London. "If used regularly we know that the need for steroids is reduced, and if they are needed, you can get away with using a weaker steroid on well moisturised skin."

At the National Eczema Society, education manager Sue Ward agrees. "Lack of education is a problem. But it could also be that GPs aren't prescribing emollients frequently enough, or when they do, the quantities they prescribe simply aren't sufficient. Some GPs are still only prescribing steroids to treat eczema. And when they do prescribe these treatments, they often don't explain how they should be used. Parents are left confused and this is where pharmacists could step in and play an important role by filling this gap," says Ms Ward.

Community pharmacist Dr Steven Kayne says: "Parents are under-using emollients and mistakenly think that steroids are the proper treatment and emollients just an also-ran. We need to educate customers by telling them what emollients can do, that you can't over-use them and that they're not active drugs. They also need to know that steroids should be reserved for flare-ups only."

At Beiersdorf, brand manager for Eucerin, Rache Jewsbury, says: "Parents also need to know their child may need more than one emollient – a more



> "Teach children an alternative response to scratching skin, such as pinching it"

Eczema treatments market

The OTC eczema treatments market is worth £50 million (IRI) and has grown by around 4 per cent in the last three years. The biggest brand is E45. The largest child-specific brand is Oilatum Junior and this sector is worth £2.8m. "I think it helps parents that a brand such as Oilatum can be purchased over the counter as well as being on prescription, as once an emollient works for the child the same one should be used all the time," says Carol Williams, consumer brand manager at Stiefel.

Advice for professionals

The National Eczema Society offers an advice service on eczema to professionals including pharmacists. The service costs £20 a year and gives you access to a dedicated team of experts. For more information visit www.eczema.org

Eczema advances

- Hope for future eczema treatments lies in the recent discovery made by scientists at the University of Dundee of the gene that causes dry, scaly skin and predisposes individuals to atopic eczema. The gene produces a protein called filaggrin, normally found in large quantities on the stratum corneum, which is essential for skin barrier function. A reduction or absence of this protein means the skin barrier doesn't work effectively and skin dries out quickly. Around 5 million people in the UK make only 50 per cent of the normal amount of filaggrin, while one in 500 of us produces no filaggrin at all.
- In terms of emollient treatment, the best recent advance has been pump dispensers as people with eczema are more prone to infection. These help to prevent this," says Dr Mayou, consultant dermatologist at Chelsea & Westminster Hospital. "Dermamist is a useful new emollient as it's easy to apply. It's an oil in a spray."

easily absorbed cream for daytime use and a richer one for night-time."

Expert tips to pass on

- "Always apply cream in the direction of hair growth, using long downward strokes. But don't rub it in as this will trigger itching," says Dr Cork.
- "Apply more frequently to exposed sites of the body such as face and hands," says Dr Mayou. Apply emollients at least twice a day, ideally three to four times.
- "Always warm the emollient in your hands first and apply more in extreme weather," says Dr Cork.
- "When using bath oil, use warm, not hot water and pat skin dry afterwards to avoid making it itchy. Never share towels as children with eczema are more susceptible to picking up infections from bacteria," says Dr Cork.
- "Try to make it a fun time for children. Paint faces on their skin with the cream, let them apply the cream to a doll. Apply emollients while they're distracted with another activity such as colouring, reading or watching TV," says Sue Ward.
- "Allow 30 minutes after using a steroid before applying an emollient, otherwise you'll spread it onto areas of the skin that don't need it," says Dr Cork.
- "Teach children an alternative response to scratching skin, such as pinching it instead," says Ms Jewsbury. "And advise parents to give children cotton mitts to wear in bed to stop them scratching."

Busting the steroid myths

While correct use of emollients will reduce a child's need for steroids, there may still be times when they are necessary and it's important that parents understand their role. "One of the biggest myths in eczema treatment is the side effects from steroids. Ask any dermatologist and they'll tell you they've never seen a child suffer side effects from using topical steroids. As long as parents follow their doctor's guidelines they're very safe and effective," says Ms Ward.

"But remember that much of the disappointment with eczema treatment arises simply because people haven't been made aware of the importance of frequent regular use of emollients and that every request for topical steroids is an opportunity for you to reinforce education about emollients," says Ms Jewsbury.

Choosing the right emollient

There are dozens of emollients to choose from, so how do you know which is right for your young customers?

"I always give children a choice – I let them try several emollients on their skin and pick the one that feels most comfortable. You'll have a much better chance of the child co-operating if they like the cream," says Dr Cork.

Dr Mayou says it's often a compromise when she prescribes a cream for a patient. "As a dermatologist, you want your patient to use the greasiest cream as this forms the most effective barrier, but patients want a cream that's easy to apply and not sticky. You have to find something that's in between these two ideals. It needs to be greasy enough to keep skin moisturised with just twice daily application – and if skin is drying out in between, the cream isn't greasy enough for them."

Ms Ward says it would be very helpful if pharmacists could get hold of sample pots of emollients for parents to try out.

Dr Kayne believes it's often a case of trial and error before finding the right products. "But parents should be made aware that their child's needs may change over time and also that formulations can change too."

Ms Jewsbury says this is one area where pharmacists could make a real difference. "Be on the alert for opportunities to carry out medicines use reviews for patients with eczema. This group is often not getting the best out of their treatment."

Complete emollient therapy

Dermatologists including Dr Cork advise complete emollient therapy. This is what it means:

- Complete emollient therapy consists of a combination of an emollient cream or ointment, an emollient bath oil or shower gel and an emollient soap substitute. These must completely replace all soap, detergents and bubble baths.
- The best way to use these is to bathe in an emollient bath oil, then apply emollient cream or ointment. This will trap the water from the bath under the oil, while the cream will further trap the water and oil.
- Using the right quantity of emollient is essential. A baby typically needs 250g of cream/ointment per week and a child 500g/week. Quantities may be less for mild eczema and higher for severe cases.

> Parents just don't understand how important emollients are

Product news

Lack of urea is thought to play a role in dry skin and eczema. Scientists at Beiersdorf have found that in the epidermis of healthy skin there are 28 mcg of urea per 2.5sq cm, but in those with dry skin the urea concentration is up to 50 per cent lower and in people with eczema it can be 85 per cent lower. The Eucerin range includes products containing urea at 5 per cent and 10 per cent. The Intensive 10% w/w Urea Treatment Cream and Lotion, specially designed for eczema, is also available on prescription.
Beiersdorf, tel: 0121 329 8800

Oilatum Junior OTC and prescription packs have been relaunched to give a consistent look to pharmacists and consumers. To ensure consistency of treatment, Stiefel has changed the names of prescription product Oilatum Fragrance Free Emollient and OTC product Oilatum Junior Bath Formula to Oilatum Junior Emollient Bath Additive. The packs will have the same information and images.
Stiefel, tel: 01628 524966

E45 offers a complete emollient therapy regime. E45 Cream comes in a pump pack to minimise skin infection and contains Medilan, a highly purified grade of lanolin. E45 Bath is an emollient bath oil suitable for children and can also be used as a shower gel. E45 Wash Cream is a soap substitute and E45 Itch Relief cream contains lauromacgrogols and urea and has an anti-pruritic effect.
Reckitt Benckiser, tel: 01482 326151

Grandma Vines is a new skincare range designed for eczema sufferers. Natural Antiseptic Gel is designed to soothe inflamed, itchy skin, while Tender Loving Hand Cream contains calendula, wheat germ oil, juniper and lavender to soothe and moisturise skin. Heavenly Feast Body Lotion contains sweet almond oil and apricot kernels and Perfect Peace Bath Soak includes rose, geranium and sandalwood oils.
Grandma Vines, tel: 0117 968 7744

The Disney range of children's toiletries has been extended with the launch of a Winnie the Pooh range. The products include Magic Bubbles Colour Changing Bath Bubbles, which turn from orange to blue; Little Softee Moisturising lotion; Ho Hum conditioning shampoo; Messy Paws Antibacterial handwash and Messy Paws Antibacterial hand wipes. All products are developed to be gentle on children's skin.
Dendron, tel: 01923 229251

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C+D News bulletin

Two-thirds unhappy

Nearly two-thirds of pharmacists in a survey commissioned by AAH are not satisfied with the Pfizer direct to pharmacy distribution model, delegates were told.

Findings from the survey compiled by Holdern Pearmain, which conducted interviews in late March and early April with 353 independent contractors owning up to four outlets across Great Britain, include:

- 52 per cent of pharmacists thought the overall quality of service had declined.
- 60 per cent of pharmacists said cut off times had worsened.
- 51 per cent of pharmacists said they were actively trying to decrease the amount of Pfizer product dispensed.

The split of contractors surveyed was: 153 AAH customers, 100 UniChem, 50 Phoenix and 50 regional full-line wholesale customers.

Understand tomorrow

Delegates at the AAH Pharmaceuticals conference in Singapore last week were urged to prepare for the unexpected. **Gary Paragpuri** was there

Pharmacists must prepare now for the possibility of significant changes in the way they do business in the future, delegates at the AAH Pharmaceuticals' conference in Singapore heard last weekend.

With changes ahead such as those around the pharmaceutical supply chain, control of entry and practice-based commissioning, pharmacists must "understand tomorrow today" in order to be better able to respond, Steve Dunn, group managing director of AAH Pharmaceuticals, said in his opening speech.

Steve Dunn on the possibilities for:

Pharmacy contracts:
"The government may decide to allocate monies in ways different to those which pertain today. Given that activity follows money as night follows day, if significant money is taken out of dispensing and put into service provision that's where pharmacy will have to go."

Dispensing:
"If there is no profit associated with dispensing, who will do it? Maybe wholesalers will have to change their business model to one where automated dispensing is performed by wholesalers on behalf of pharmacists and their patients."

Control of entry:
"We traditionally argue that control of entry is necessary for ensuring that there is both a geographical spread of pharmacy services provision and that there is no financial impairment to pharmacy...but one might argue that free competition would drive up standards, quality and the breadth of service provision."

Retailing:
"Time pressures mean that traditional opening hours are no longer going to be appropriate and successful retailers will match the times at which they provide services to the times that customers are prepared to buy them."

Develop **new services**

Pharmacy must develop new services in light o the government's increasing focus on cost savings, PSNC chief executive Sue Sharpe has suggested.

Areas such as public health are a "major opportunity" for developing services as the government looks to using central procuremen to deliver higher quality public services and better value for taxpayers, Mrs Sharpe explaine

Although there is "no movement" to change the current procurement systems in pharmacy Mrs Sharpe said there is a need for the DH and pharmacy to show that the existing system is "delivering good value" for taxpayers.

The government had a "tremendous focus o

Pharmacists with a **Special Interest** today

The speaker: Beth Taylor, national development lead, NHS Primary Care Contracting
The topic: Pharmacists with a Special Interest (PhwSI)

What's a PhwSI?
- A pharmacist who (in addition to their core role) delivers a clinical service beyond the scope of their professional role.
- A PhwSI must demonstrate skills and competencies to deliver the service without supervision.
- A PhwSI is not required to be a prescriber but this may enhance the scope of the role.
- A PhwSI will normally practise across a PCT or within a clinical network.
- A PhwSI and the service he or she provides must be accredited.

What can a PhwSI offer patients?
- A wider choice of NHS services, conveniently located in the community.
- Pharmacy-based clinical care that is integrated with other NHS clinicians.
- Confidence that the NHS service offered is as good as that available from a hospital or GP.

Beth Taylor: commissioning opportunities await specialist pharmacists

> "Three resources will be available within the next month"

What's in it for pharmacists?
- Recognition of advanced clinical practice beyond core pharmacy role.
- An opportunity to be commissioned to provide some of the specialist NHS services that will increasingly move to primary care.
- Playing a key part of the local clinical network.
- Greater security in the long-term because if service level agreements specify PhwSI then other providers must meet this criteria.

What's in it for commissioners?
- Supports DH policy of care closer to home.
- Meets 18-week waiting and 48-hour access targets.
- Maximises healthcare skills.
- Secures quality.
- Multi-professional teams can be based in primary care to support people with long-term conditions.

Where's the funding?
- No national contract – PhwSI services will be negotiated locally.
- Possible new funding streams may be linked to redesign of care pathways that move care into community settings.

What evidence will pharmacists need to get PhwSI accreditation?
- Formal learning such as a university course.
- Experience in specialist area to date.
- Learning through supervised practice.
- Evidence of competence in core role.

Where can I get more information?
- Three resources will be available within the next month: an introduction to shifting services into the community; a guide on redesigning patient pathways using PhwSIs; and a nationally recognised accreditation process for pharmacists and GPs with a special interest.
- www.primarycarecontracting.nhs.uk/119.php

Examples of current services that could transfer to PhwSI?
- Tim Cottingham, Cottingham Pharmacy, NE Lincolnshire: provides dedicated dosing, needle exchange, dedicated CD storage.
- Rimal Patel, New Park Pharmacy, Lambeth PCT: provides EHC, chlamydia screening and treatment, pregnancy tests and condoms.
- Noel Dixon and John Hall, Derwentside: provide anticoagulation service for 900 patients with flexible appointments, which has been running for 10 years.

procurement" and, with primary care pharmaceuticals representing almost half of the total £17 billion annual NHS spend on goods and services, Mrs Sharpe said it was "immensely important" to recognise that procurement could be used for cost savings.

She highlighted how the DH commercial directorate had already cut the prices of dressings and chemical reagents and was seeking price reductions on stoma and incontinence products.

Although the impact of the government's procurement policy on pharmacy had to date been "minor", Mrs Sharpe said it was "no longer a viable business model" for contractors to base their income model on purchase profits.

Control of entry

100-hour pharmacies are emerging as the "big problem" of the control of entry reforms, Mrs Sharpe told delegates.

Instead of being geographically spread out in areas of need, there had been some clustering of 100-hour pharmacies as well as some 100-hour pharmacies opening in GP surgeries. "What we have seen is not what the government had expected," she said. Commenting on the current control of entry review, Mrs Sharpe said that, under its terms of reference, it could go "right into the heart" of the current pharmacy contract structure and pose "quite a threat".

In two meetings with the Galbraith review, PSNC has "pushed for a strong" national contract and called for PCTs to be able to develop pharmacy services in line with patients' needs, she added.

Brown to set up **NHS Exec?**

Gordon Brown could set up an independent executive board to oversee the NHS if he becomes prime minister, a leading health expert has predicted.

The chancellor may make a series of health policy changes after succeeding Tony Blair in June, predicted Niall Dickson, chief executive of the King's Fund.

There are likely to be fewer health targets, devolved decision making, and a pegging back of pay rises, in addition to the NHS board, Mr Dickson suggested.

Mr Brown will want to encourage stability in the NHS in the run-up to the next general election in 2009, Mr Dickson told delegates.

Other options for Mr Brown could include a process to benchmark commissioning in order to allow useful comparisons to be made, and the continued use of choice to drive NHS productivity, Mr Dickson added.

The NHS in England is also likely to see a funding downturn after the government's comprehensive spending review this year, with a real terms increase limited to less than 3.5 per cent, Mr Dickson said. Following the increased levels of funding over the past years, there will instead be a reliance on increased production to deliver better care, he said.

Future PM wants a stable NHS, said Niall Dickson

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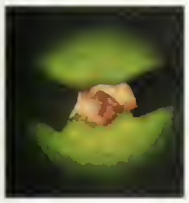

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Bon Viveur

I love Sunday lunch. A lie in, perhaps a trip to the local pub while the food gently cooks in the oven, discussions with friends and family around the table, a bottle or three of wine and a snooze in front of the TV afterwards. A familiar and cherished vision of Britishness that today is honoured mainly in the breach, annihilated by the pressure of seven-day supermarkets, Sunday working and the fragmentation of the nuclear family.

The traditional Sunday roast can be traced back to medieval times but the format familiar today arose in England during the 19th century. Probably the tradition began because the meat could be left in the oven to cook during church on a Sunday morning and would be ready when arriving home at lunchtime; and, of course, Sunday was the only day of rest for all the family as the majority of workers were required to put in six days a week in the mills, mines and counting houses of the industrial revolution.

I'd like to start a campaign to bring back Sunday lunch (along with warm beer, pubs with bar billiards, winning at cricket and flogging as a punishment for yobbishness, if you're interested)

There is no sincerer love than the food of love (George Bernard Shaw)

and long lazy afternoons eating and drinking with friends; but recognising that cooking all day is not necessarily appealing to many pharmacists after a week of dispensing, I suggest we focus on where to get a good Sunday lunch when eating out. Here are four recommendations.

The French Horn, Sonning, Berks
Set aside the Thames in a twee village, ducks roasting in front of an open fire, kitchen viewable, dining room with great views of the river. Relaxed Sunday lunch, excellent crab tian, good wine list, food expensively average but an appropriately languid occasion.
www.thefrenchhorn.co.uk

The George – Stamford, Lincs
Only one reason: poached lobster with mayo and chips (go now before they take it off the menu). And Stamford is a very pretty town in which to walk off your overindulgence afterwards.
www.georgehotelofstamford.com

Sharrow Bay – Ullswater, Cumbria
The original English country house hotel that defined the genre. The decor is a bit OTT but it possesses a superb view across Ullswater to Place Fell and beyond. Fillet steak topped with a miniature steak and kidney pudding was superb.
www.sharrowbay.co.uk

Buckland Tout Saints – Goverton, Kingsbridge, Devon
A jewel of a hotel, 17th century originally, buried in the South Devon Hams, almost inaccessible down narrow country lanes and set in glorious grounds. This is a wonderful, tranquil, hidden treasure of a hotel. Some of the rooms are magnificent; the reception rooms are comfortable and welcoming. The standard of cuisine is good but the location is simply to die for. Tranquil, relaxing and romantic.
www.tout-saints.co.uk

Of course, we have to consider what to drink as well. With roast meat, tradition would dictate claret, not the modern plummy style of the Right Bank, so beloved of Robert Parker and America, but the complex spareness of the Left, St Julien for my preference, perhaps an Amiral de Beychevelle (second wine of Chateau Beychevelle, shouldn't break the bank). Or a Hermitage from the northern Rhone, syrah with a touch of marsanne and rousanne, drink when old (the wine, not you).

Would I go here again?
All of these restaurants have my hearty Sunday lunch endorsement

What would I change?
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